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ABSTRACT

Health care reform's direct effect on higher education and labor is the subject of this conference report. Individual, panel, and interactive work group presentations addressing the values and options on health care issues are included. Following an introduction, three papers discuss the U.S. health care system: (1) "National Health Care Reform: The Time Is Now" (Thomas Donahue); (2) "The Public's View of the Future of Health Care" (Robert Blendon); and (3) "Is a Radical Change in Health Care Financing for the United States in the Offing?" (Stuart Altman). Panel presentations on "Labor-Higher Education on Health Care Reform" include the following: "Labor's Perspectives: The Need for Health Care Reform" (John Sweeney), Gerald McEntee); and (2) "Higher Education's Perspectives: The Campuses and Health Care Concerns" (W. Ann Reynolds, Joseph Duffey). Work group reports are summarized on the values and options for health care reform. Finally, the report includes "The AFL-CIO on National Health Care." Two appendices on the "Labor/Higher Education Council" and "Statement: Labor in Higher Education Governance" are included. (NLA)

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HEALTH CARE REFORM: AMERICA'S DILEMMA

LABOR/HIGHER EDUCATION COUNCIL
of The American Council on Education
and The AFL-CIO

Report on the National Meeting
November 28-29, 1990
Boston, Massachusetts

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HEALTH CARE REFORM: AMERICA'S DILEMMA

LABOR/HIGHER EDUCATION COUNCIL
of The American Council on Education and The AFL/CIO

Report on the National Meeting—November 28-29, 1990
Boston, Massachusetts

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PREFACE

"Higher education and labor have many philosophical things in common, including freedom of thought and freedom of expression, and I am pleased to see them coming together."

John Dunlop
Lamont University Professor Emeritus
Harvard University

This report emerges from the Labor/Higher Education Council's national meeting held at the Sheraton-Boston Hotel and Towers November 28-29, 1990. The meeting theme, "Health Care Reform: America's Dilemma," arose from the views of representatives from the American Council on Education (ACE) and the AFL-CIO that health care reform directly affects both sectors, and the American public generally. They also believe labor and higher education are positioned to raise the issue with the organizations, institutions, and members they represent, and with the American public.

The flow of the meeting encompassed formal presentations by nationally recognized experts on health care reform, a panel of national leaders in labor and higher education to offer diverse perspectives on health care from their sectors, and highly interactive work groups led by Council participants which addressed the values and options we face on the health care issue.

The 61 participants represented, on the labor side, 18 international unions, 8 state AFL-CIO federations, and 6 AFL-CIO departments. From the academic side, there were 16 colleges and universities represented by senior academic leadership, along with leaders of ACE-affiliated associations.

Thomas R. Donahue, Secretary-Treasurer of the AFL-CIO, Robert J. Blendon, Chair of the Department of Health Policy and Management at Harvard University, and Stuart H. Altman, Dean of the Heller School of Social Welfare, Brandeis University, laid out the task for the labor and higher education participants in their opening addresses. Donahue talked about organized labor's stake in national health care reform, calling our health care system "our great big peculiar mess." Blendon offered analysis of national and international surveys of public attitudes towards health care, with some surprising findings for policy makers. Altman talked about previous efforts at national health care reform, saying the time is right for a new approach, but that coalitions of interested parties will be necessary.

Judith Eaton, Vice President of ACE, moderated a panel of labor and higher education representatives who offered their distinct perspectives on the nation's health care dilemma, and options for change. The panel members included Joseph Duffey, Chancellor of the University of Massachusetts at Amherst; Gerald W. McEntee, President of the American Federation of State, County and Municipal Employees (AFSCME), represented by Robert McGarrah, AFSCME's Director of Public Policy; W. Ann Reynolds, Chancellor of the City University of New York; and John J. Sweeney, President, Service Employees International Union (SEIU).

Participants also had an opportunity to offer their personal views in a series of work group discussions, addressing the values that will have to underlie public policy on national health care and the choices we face for reform. Chairing the four work groups were Lenore Miller, President of the Retail, Wholesale and Department Store Union (RWDSU), Ronald E. Beller, President of East Tennessee State University, Edward J. Liston, President of the Community College of Rhode Island, and Jack Sheinkman, President of the Amalgamated Clothing and Textile Workers Union (ACTWU). Jack

Golodner, President of the Department for Professional Employees, AFL-CIO, shared the Chair with Jack Sheinkman.

The work group reports represented the participants' consensus on both the values which will have to be present in any system of national health care and some of the basic elements for a reformed system. Summaries of these reports, as they were presented to the meeting participants, are included as the final section of this report.

In its annual business meeting, the Council participants endorsed the Council's Steering Committee Report, advocating the continuation of the initiative for state-level dialogues, and adoption of a new statement on labor representation in higher education governance — "Labor in Higher Education Governance."

ACE and the AFL-CIO jointly produced this report of the National Meeting on health care reform, and the support of the senior leadership of these national organizations has been key to the Council's continuity and success.

Thus, the Council acknowledges the leadership brought to the Council by Robert H. Atwell, President of ACE, Lane Kirkland, President of the AFL-CIO, and Thomas R. Donahue, Secretary-Treasurer of the AFL-CIO. Judith Eaton, Vice President of ACE, and Dorothy Shields, Director of the Department of Education, AFL-CIO, provide day-to-day assistance and support for the Council's Steering Committee and staff.

Dr. John Dunlop, former Secretary of Labor and Professor Emeritus, Harvard University, during his remarks to the Council

INTRODUCTORY REMARKS

"We look to you as partners to address the issue, and provide us with your views and guidance as a result of your deliberations here."

Dorothy Shields
AFL-CIO

"We have an unusual opportunity to advance the debate on health care reform..."

Judith Eaton
ACE

Dorothy Shields, *Director, Department of Education, AFL-CIO*

When the AFL-CIO and ACE sat down to plan the 1990 Council meeting, we realized that our national health care system was a common issue for all Americans. It directly affects our constituencies—our members, our employers, our institutions—with deep ramifications for the fabric of American society. So we considered health care reform to be an issue appropriate for this joint meeting.

For labor, we have a long history of seeking strategies to help workers obtain health care through collective bargaining, and to gain public support for health care legislation. Many unions have joint agreements with their employers to seek a consensus for this problem. There are no clear answers, but we believe the AFL-CIO principles can be a useful starting point for our discussions. The principles include access to health care for all Americans, affordability, and quality of care.

We look to you as partners to address the issue, and provide us with your views and guidance as a result of your deliberations here.

Judith Eaton
Vice President, ACE

ACE is involved because we believe the Council is an important vehicle for expressing the partnership that exists between labor and higher education at the national level. We are pleased to be here for two reasons. We believe the topic of health care reform is important—clearly critical, and clearly calling for the attention of many people from all walks of life. And we are delighted that labor and higher education have an opportunity together to deal with this challenge.

There is no other group of this nature that can speak to national health care reform from a national perspective and we value the benefits of this unique partnership. We have an unusual opportunity to advance the debate on health care reform, and to develop ideas and strategies over the next two days to help us accomplish this goal.

Arthur Osborn
President, Massachusetts AFL-CIO

Health care reform will be the major issue for our country in the 1990s, and I can't think of a better group to address the issue. We can combine the knowledge higher education can offer with the principles of organizing from the labor movement to move the public's thinking on the issue.

1. AMERICA'S HEALTH CARE SYSTEM: READY FOR CHANGE

Thomas R. Donahue, Secretary-Treasurer, AFL-CIO

NATIONAL HEALTH CARE REFORM: THE TIME IS NOW

Thomas R. Donahue
Secretary-Treasurer, AFL-CIO

These meetings of the Labor/Higher Education Council are about education, not about right or wrong answers to issues affecting both labor and higher education. The meetings are concerned with how to think about the problems of education and labor, our interrelationships, and our interactions.

Thanks for all those on the AFL-CIO and the ACE side who do so much to maintain this relationship, and from our standpoint, who make the presence of labor and the importance of labor effective in the education community. And I hope that those from the education community make its presence among the labor movement an important factor in the things we do.

The focus of this national meeting, national health care reform, occupies all our attention, occupies a good share of the assets of our organizations, and this discussion brings the relationship between the labor movement and higher education to a more specific focus.

This is the seventh annual meeting of the Council. All of us who have participated can attest to the value of this process. We learned a lot about each other over the years, we've talked about where our common interests lie, and we've explored ways we can work together.

This meeting focuses specifically on "National Health Care Reform: America's Dilemma." It raises questions of just what is a dilemma. It is a term of logic, but today we use it when we face two or more courses of action and none seems completely satisfactory. It is a sobering thought. That's how we describe our health care system and our health care problems—we are presented with a number of alternatives. There's no clear, easy, perfect solution to the dilemma. There are solutions, however, that are less bad than others, and what we're trying to do in these two days is think about how we approach them.

I would have enlarged the title to: "How Do We Approach America's Great Big Peculiar Mess?" That may not be elegant, but it describes very particularly the health care problem in our nation. A great big peculiar mess—particular to us as a nation.

Consider the fact that 11 percent of our GNP goes to pay for health care. We spend 11 percent of our national product and we wind up with 37 million people with almost no access to health care, and millions more who are badly underinsured. Consider the fact that we are, by far and in spite of our debts, the wealthiest nation in the history of the world. We've been one of the most generous nations in the history of the world.

That is a simple truth, yet we are only one of two industrialized nations in the world that doesn't assure basic health care to its citizens. And our only companion, and a fairly dubious one at that, is South Africa.

Consider the fact that the overwhelming majority of Americans—86 percent—believe the federal government is responsible for guaranteeing that all citizens receive health care. You would think that 86 percent represents a fairly strong national consensus, yet whenever a serious proposal on this subject moves forward, somehow 86 percent doesn't represent a sufficient consensus to move the Congress or to move an Administration.

Consider the fact that there is nobody who likes the current system. Most patients, would-be patients, those deprived of services, certainly doctors, hospitals, nurses, employers, and unions think it is a crazy, hodge-podge system. Yet like Old Man River, it just goes rolling along.

Those are the points of your dilemma, the identifying marks of the dilemma we face which defines "our great big peculiar mess." That's what we are here to discuss. If we, this group, are to aid in forming the solutions, we have our work cut out for us.

Dr. Robert J. Blendon, Professor, School of Public Health, Harvard University

THE PUBLIC'S VIEW OF THE FUTURE OF HEALTH CARE

Robert J. Blendon
Chair, Department of Health Policy and Management, and Professor, School of Public Health, Harvard University

Our Center analyzes polls on health care, medicine, and related issues. Over the past few years, we've summarized over 1,000 polls on health care, 100 in the past year alone.

Health care is on no one's agenda, but the public is more interested in national health insurance than at any point in the last 40 years. The man in the street is saying, "This health care issue really bothers me." The issue has emerged without anyone's effort. We are going to have a debate about it.

By going through these polls, we have literally talked to 100,000 Americans about what they would be willing to agree to or not agree to in their health care system. Here are some of our findings.

What Bothers the Public About Health Care

The issue that is emerging has to do with working people, and the traditional view of the uninsured or the underinsured as poor people or the unemployed. The angriest people in America at this moment are working people who are employed—six out of ten people without health insurance are working people.

When you poll people and they say, "I have trouble with my insurance," they tend to think they are the only ones with the problem. It's only poor people who have this problem. But it's really working people who are uninsured in the U.S. People don't realize this—they still think it is the poor or the unemployed.

For example, public support for a government-financed national health plan is slightly higher than in 1965 when Medicare was enacted (Chart 1). Most of the change in public attitudes occurred between 1982-1989, and the people who changed their mind between 1982 and 1989 are all working people. What happened was that workers, most of whom have insurance, are now for national health insurance.

Every year, the Conference Board poses a list of economic and social issues to the public—"What are the most important problems that worry you?" For the first time, in 1990 (Chart 2), the cost of medical care is at the top of the Conference Board's list. All through the 1960s, the nuclear war threat was number one. So people are angry. The Cold War is over, but we got the Gulf Crisis. The Cold War is over, but we got the Recession. But what they are saying is when the Gulf Crisis is resolved, when we are out of the recession, what do I want done? Schools and health care are uppermost—Americans want to do something about these two issues.

Comparisons With Other Countries

We surveyed the populations of 10 countries, asking how satisfied they were with their health care systems (Chart 3). Americans and Italians were the most dissatisfied with their health care systems, and the Italians spend $800 per year per person and we

spend $2,100. The Canadians were the most satisfied. If you listen to the AMA, you wouldn't think there was a single Canadian happy with their system, but the Canadians don't seem to be aware of that.

We rank at the bottom. Why are Americans so angry with their health care system? We compared American views with Canadian views (Chart 4), asking: "Are you satisfied with the care you are getting from your doctor or hospital?" It turns out that Americans are very satisfied. But ask about their health care system, and there is an enormous difference.

Why Americans Are Upset With Their Health Care System

The debate is beginning to take off, with Americans offering the following as reasons for their concern with health care.

Being Uninsured While Working—We have not understood the dynamics of being uninsured. Over two years, 28 percent of our country is uninsured—changing jobs, going part time, being a seasonal worker. But the way officials describe it is as "the pool of uninsured," as if they have been there forever. Not true—the bulk of people who are uninsured have insurance, but they are rolling in and out of jobs that are covered, or they change their circumstances. As a result, the number of uninsured is increasing by 700,000 people a year—all working people.

We are controlling health care costs by taking insurance away from the workers or their families. Even firms with good hours and conditions often don't offer health insurance.

Chart 1

Support for a National Health Plan That is Totally Government Financed

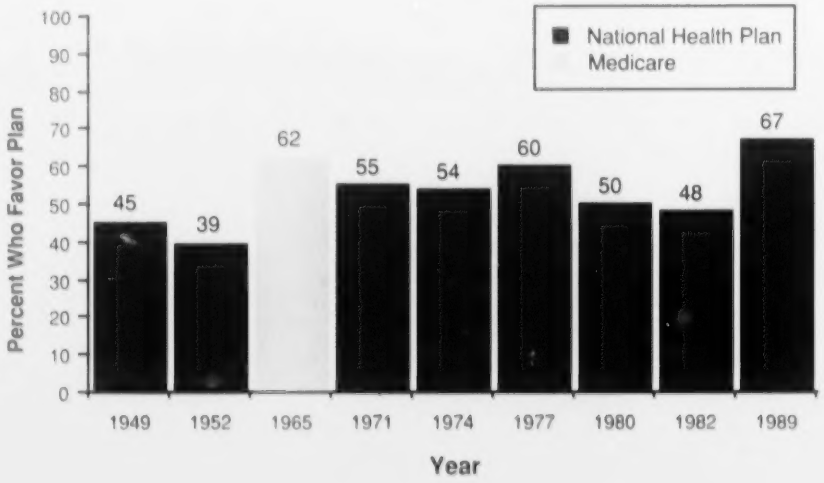
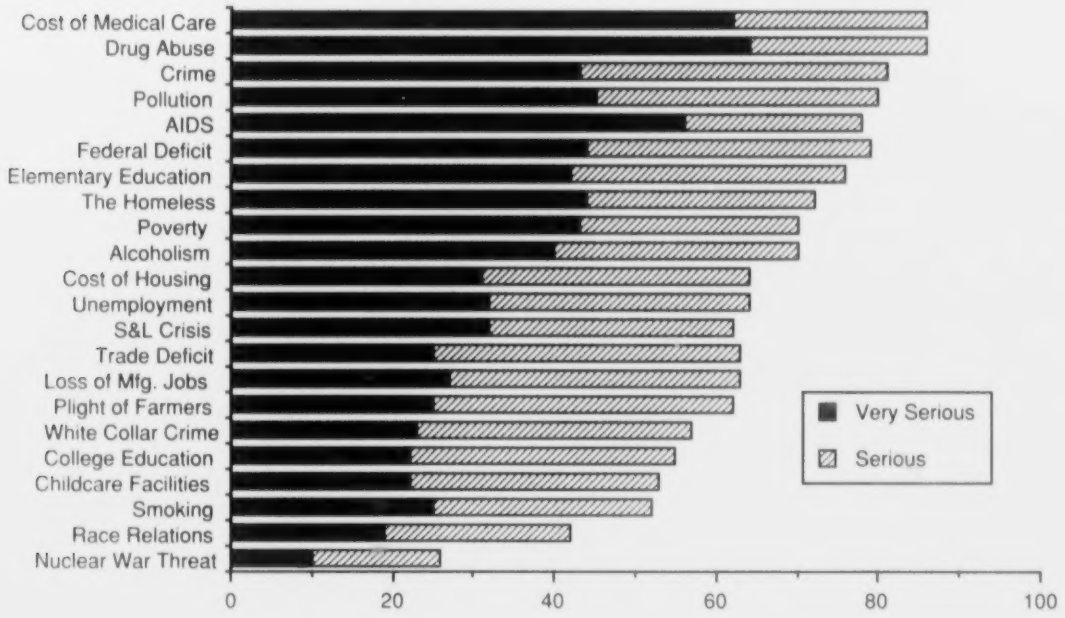


Chart 2

Here Are a Number of Economic and Social Issues That Are Causing Many People Concern. How Would You Rate the Seriousness of Each?



Inability to Control Costs—Employers don't know how to control their health care costs. What they have been doing is increasing the share paid by their employees. In 1980, the average employer paid 80 percent of the health care bill for employees; it is now down in the low 60 percent range.

Employer Requests for Concessions—From the surveys, 1 in 6 people are saying in the last two years that their employer has called them in and said, "Remember the benefits I promised—I'm cutting them." We have a large number of workers who have health insurance, but their benefits are being cut. This is the crowd that is saying: "Tell me more about this national health insurance stuff. What is this plan for health care reform?"

Working people are beginning to get very interested in the issue. They are concerned because they think they are financially insecure. But here comes the AMA saying—Americans are not dissatisfied with the actual care they get (Chart 4). You can scare most working Americans if they think you are going to radically change their relationship to their doctor or to their hospital. They are not prepared for radical change, and if they hear that what you are talking about is a radical change between their doctor and their families, they won't go for it. Sure, control costs, but if you're going to this other stuff like rationing health care, Americans get nervous.

Real Issues for Americans: Setting Priorities

Let me summarize our hundreds of interviews about the real issues for Americans. Health care

reform is still a "second burner" issue for the average American. Americans will walk away from this kind of issue if they become economically scared. People are angry with the government, scared about the recession, and worried about the Gulf Crisis. So when you say we are in financial trouble, it's easy to walk away from the health care issue. Deal with it later.

But when health care reform is not threatened by the "big tier" issues, then it becomes very popular. Further, people who call themselves "Republicans" and people who call themselves "Democrats" differ on the health care issue. For Democrats, it is a big issue—they want something done about it. This means that wherever the domestic agenda goes over the next three-five years, the Democratic agenda with health care reform gets great support. But for President Bush, it doesn't seem to be a problem. In the core Republican group, they do not see it as a problem. So it could turn out to be a very partisan issue. Democrats seem to be angry, Republicans are more relaxed about the issue.

Private versus Public Insurance: The Debate

The next point is important for the union movement. There is a clear split in this country on what health care reform should entail. There are Americans who think a national health plan means patching up the existing system. A law mandating employers to carry private insurance with minimal benefits would suffice, with government doing something for the unemployed. They'll be against it if the plan is all government.

Chart 3

Percent of Citizens Who Think Their Nation's Health System Works Well

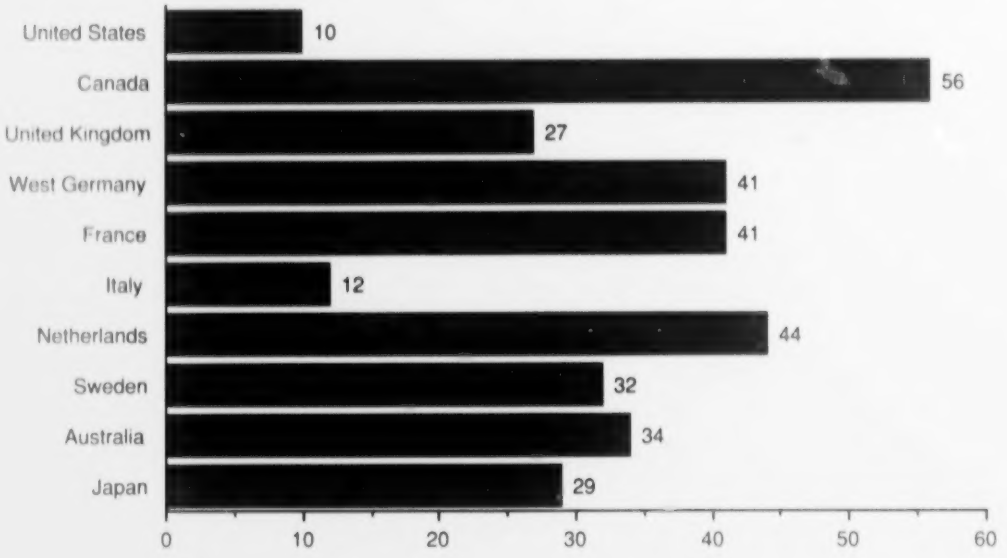
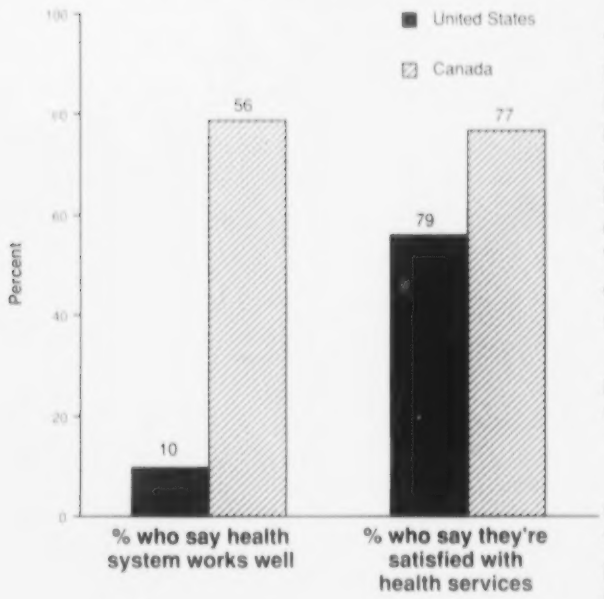


Chart 4

Satisfaction with Health Systems and Services, 1988-89 United States and Canada



Source: Louis Harris & Associates, USA and Gallup, Canada

On the other side is a large group of Americans who are sick and tired of private insurance. They are very angry with the current third party payor system. When they think about national health insurance, they don't think about extending the current insurance system. They like Medicare—their mothers and fathers are getting a better deal than they got.

So we interview them on the telephone and ask: "How would you like a health care plan financed from Social Security?" They answer: "If it's like Mom has, it's not bad. She's paying the doctor less than I do under Medicare." So there is a growing number of Americans who are saying, "It wouldn't be so bad to have Medicare take this whole thing off our backs." What is important is they don't agree. There's a big split. And we'll never get a plan in this country unless we can get the two groups under the same umbrella.

Right now we do not have a bill on the table that gets full support of either those who want to stay with what we have, or those who want major hanges. When we had a bill on the table in the 970s, the unions said we're going to hold out for an all-government program. The Republicans said we're going to hang in for a private insurance program. We got no program. Unless we can finesse the differences when the debate starts, unless we can get some compromise, we'll end up with nothing. There is a significant split.

Who Pays, Who Benefits

Consider the Medicare catastrophy on catastrophic insurance. Retirees' initial enthusiasm for catastrophic insurance lasted a year before they realized they would have to pay for it. Then it died. As long as younger people were paying for it, it was a hot item.

According to the polls, the elderly, basically middle-class, said, "I will not support a major new health care program that I will not get a lot of benefit from, and I don't get a lot of benefits from this catastrophic insurance." Second, they said, "I'm willing to help people who are old, but not alone. I'm willing to pay a modest tax increase to help the poor and less fortunate, but not a big tax increase. This is too much." Finally, they admitted: "I hate the income tax. What right do you have to do it?"

Americans in general feel the same way as the middle-class elderly (Chart 5). The middle class are not interested in a national health plan that only helps the poor and the unemployed. They say: "It has to help me too." Besides, the support for national health insurance falls off as soon as the tax increase rises above the modest level—$100-150 per year (Chart 6). Americans want to know how much it will cost them. How much in taxes? What will it really mean for me? If Americans find out they will be paying thousands of dollars in new taxes for health insurance, they will give a negative reaction. Unless people believe it's a moderate tax, and it's going to stay a moderate tax, you're going to scare them.

Views on the Poor and Public Assistance

Americans can't get over the fact that they really dislike people on public assistance. It takes a private phone call, not a group discussion, to get this out. For 20 years, the University of Chicago's National

Opinion Research Center has been asking Americans to rank the things you want government to spend money on, and there are 17 items. The lowest ranking is always foreign aid and right above it is public assistance and welfare (Chart 7). Above that are prisons, parks, even rebuilding highways rather than spending for public assistance.

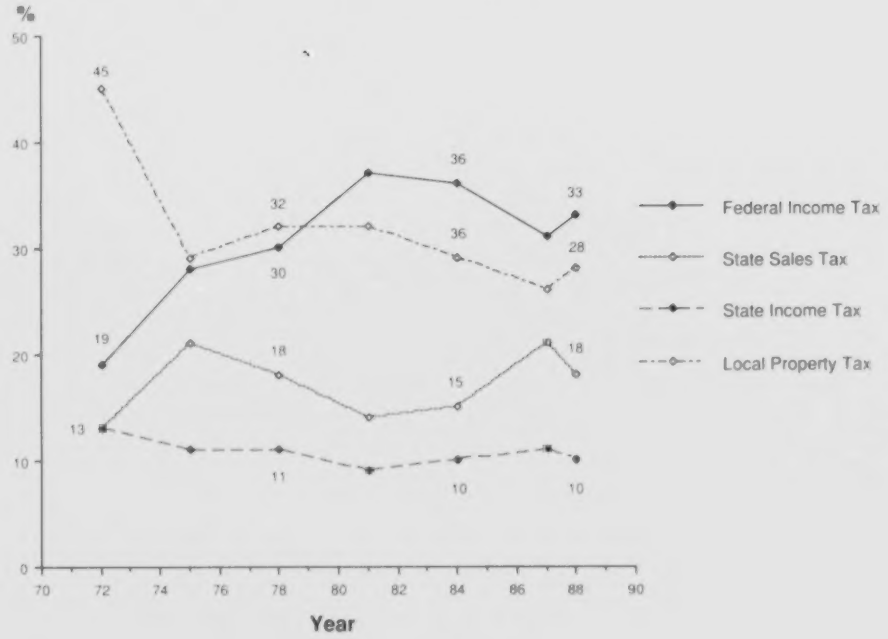
Ask Americans: "Do you want to help people who are poor and low income?" "Sure," they reply. "Would you expand the program of public assistance?" And they respond, "No." But the only health care program for low-income people is Medicaid, which operates through public assistance. If we ever have a major national health care program, we have to get low-income Americans out of the welfare system. People are simply too angry at the public assistance program.

While the debates go on about the nation's elderly, the last person the average American wants to ration care for is the elderly. The person they are willing to ration care for is anyone on welfare. Look at the Oregon experiment with rationing. The elderly are exempt. The people who are eligible are poor children and their mothers. The elderly are exempt because no one could politically deal with them.

Pollsters understand that the real political strength is not the elderly—it's the average American adult who asks: "Who will pay for Mother without Medicare—me. So I'm supporting Mother's Medicare program to the end." There is incredible support for the elderly and not for rationing care. But there is very little support for low-income people. Hard choices are being made about people under 65, mostly minority and young.

Chart 5

Which Do You Think Is the Worst Tax -- That Is the Least Fair?
1972 - 1988



Concern for Health Care Costs

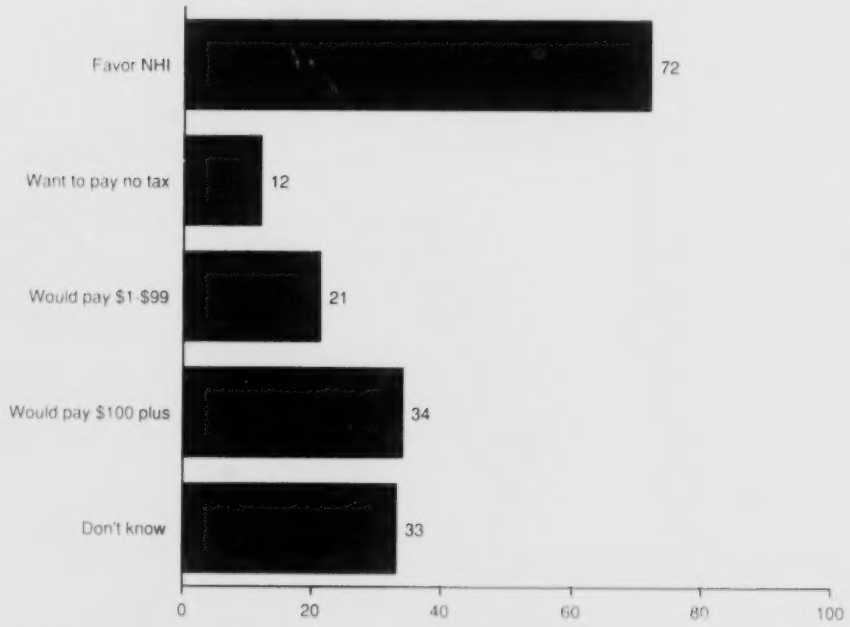
My next point is the issue of cost containment. Let me summarize three sets of polls—for employers, doctors, and people in general. Employers and doctors actually think alike. They think most or a good deal of the health care problems facing this country are the fault of people—the employees. They don't take care of themselves, they don't use medicine, they are overly demanding, they get tests and technology they don't need—all increases in health care costs must be due to the behavior of employees.

The people themselves see it exactly opposite. The problem lies with doctors and hospitals. And if you probe them, they'll throw in the insurers—the insurers should be controlling the doctors and hospitals. They don't see themselves as responsible at all. Employers are saying, "Limit choices, cut back on benefits, make the system more cost efficient." Whereas the man in the street is saying, "The more you cut back the benefits, the more I want the government to take over the program." The public doesn't believe the doctors and the hospitals can be cost efficient. If we want to get the employers to the table in a national health insurance debate, some of the proposals are incredibly draconian for employees. The American worker won't go for them.

Americans' views on controlling health care costs are as follows: "Do whatever you can do, unless it affects my own doctor or hospital." Everybody thinks their doctor or hospital could be paid less. Everybody is terrified of being in a hospital or nursing home. "Managed care" is the new gimmick to control costs. The secret is to have you

Chart 6

Support for National Health Insurance and Willingness to Pay Taxes to Fund It



Source: Los Angeles Times, 1990

go into the hospital and be operated on less. Americans are scared to have more surgery than they need.

HMOs are like Volvos. There are a group of Americans who believe passionately they are the best plans, but they are not the bulk of Americans. Research shows 14 percent of the insured belong to an HMO, and 30 percent say they would join the right plan at the right time. If you say in polling that national health insurance means joining only one HMO, Americans will respond on the polls: "I don't want national health insurance." If you say, as the AMA did in their ad campaign, "You'll have to wait for surgery," it will scare a lot of Americans. We are used to getting into a hospital fast. The public is not prepared to wait.

Or, if we say to Americans, we're going to close every hospital in rural Oklahoma and you'll get the best care four to eight hours drive from where you live, the public will not buy it: "Improve my coverage, great, but if you're talking about rationing or limiting my choices of doctors or hospitals, I don't want that system."

This is a real debate. The business community won't come to the table without big savings out of any plan. The man on the street says, "I'm for big savings, but don't take it out of my plan—take it out of the doctors and the hospitals."

The Public's View of Medical Leadership

How do Americans feel about doctors? There has been an incredible fall from grace in American views about leaders of medicine (Chart 8). Why? In an analysis of 100 studies, the public is saying: "They're only concerned with money." Doctors are

Chart 7

The Public's View of Spending on Health and Welfare

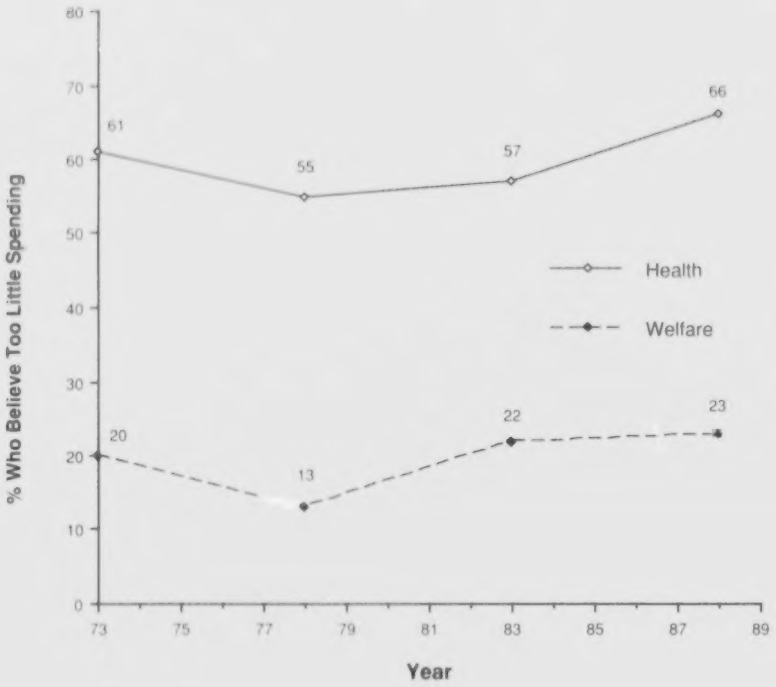
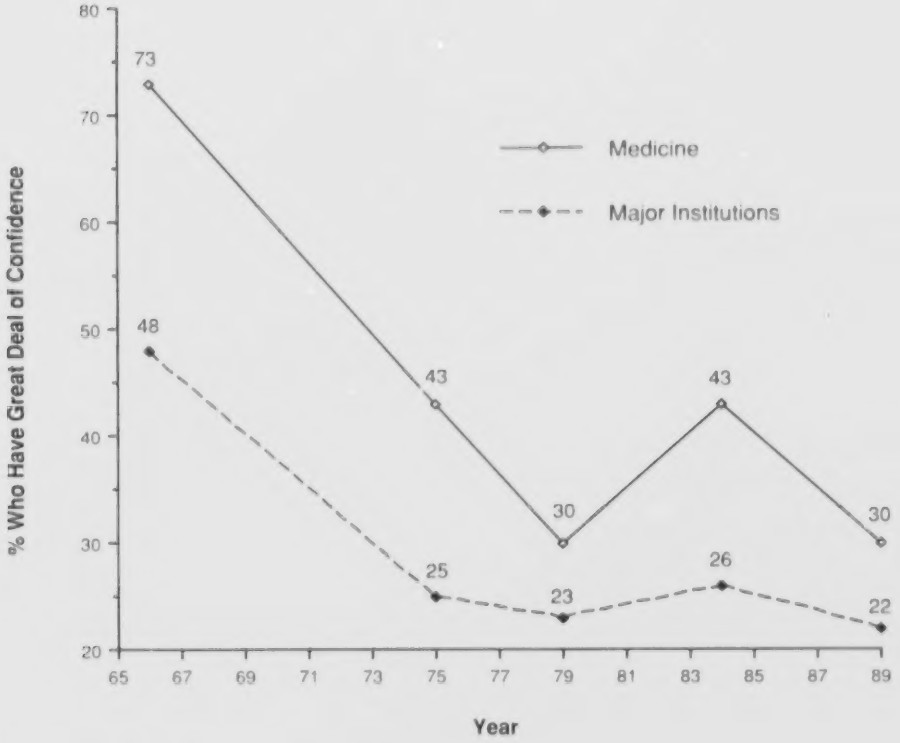


Chart 8

Confidence in Leaders of Medicine vs. Other Major Institutions
1966 - 1989



Source: The Harris Poll

no longer special; they're fixated over money. But when you talk about care or illness, the public wants doctors to make the decisions. It's only when the word money appears that they want someone else between them and their doctors.

In fact, average Americans don't think a lot of most of their leaders—we don't trust our institutional leadership (Chart 9). In 1965, 65 percent of the public reported confidence in leaders of medicine; in 1990, it is 29 percent. Leaders of all other institutions also fell in the public's confidence, but physicians who were formerly among the most prestigious group, are now among the average.

In a major public debate, physicians' views will count, but not the way they did 25 years ago. Their money and clout still does count, but it won't be the same as when they were riding high. Even though physicians will not play a leading role in this debate, it will be hard for anyone to do so.

If there is going to be a national health care plan, there will have to be a coalition of leading groups who agree on what it will look like. No one institution will have the public's support in today's cynical world to develop it. As soon as it becomes the "union plan," or "the doctors' plan," a lot of people will turn off. We need a plan simultaneously signed by a coalition of groups—or we'll lack consensus.

Building Coalitions for National Health Insurance

Among industrialized countries, Americans worry less about evening out the differences between wealthy and non-wealthy people (Chart 10). Income

taxes tend to be fairer than flat taxes, yet Americans are unenamored with progressive taxes.

Table 1

Americans' Preferences for Universal Health Insurance System Options, 1972 and 1976

Option I:	1972	1976	1990
Favor an all government national health plan	22%	27%	46%
Option II:			
Favor a compulsory private insurance plan with government providing for the unemployed	40%	38%	33%
Option III:			
Favor no change in present system	30%	27%	19%

Source: Louis Harris and Associates, Inc.

Americans are split (Table 1) between an all-government plan like Medicare (46 percent) and having their employers provide health insurance with government taking care of the rest (33 percent). But status quo people have declined between 1972 and 1990 (30 percent down to 19 percent), and suddenly Americans are saying, "I could go with an all-government plan."

Chart 9

Who Does the Public Believe?

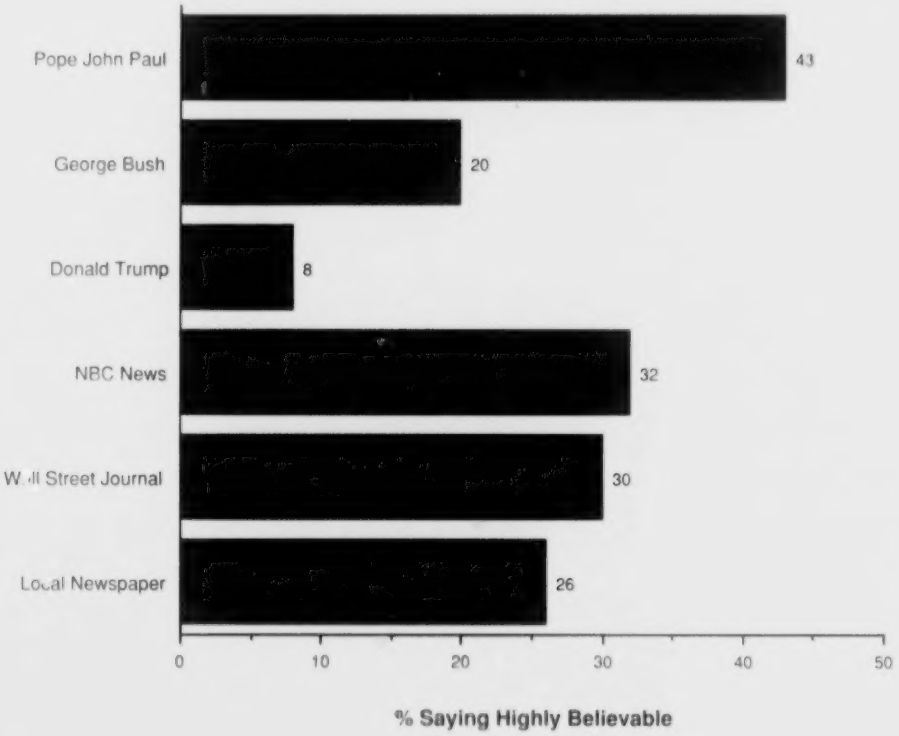
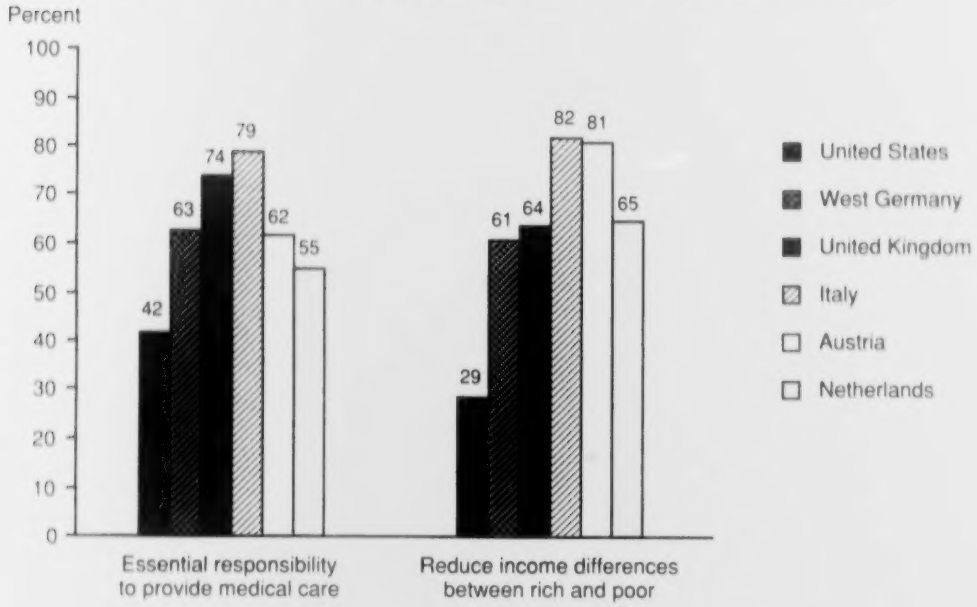


Chart 10

Six Nations View the Responsibilities of Their Governments



Noteworthy is that two-thirds of Americans favor national health insurance, but don't favor the same plan. Unless we can get them together in a proposal, one of the major players will join the "just say no" crowd. We have two-thirds of the public requesting a specific national health insurance plan, even though two-thirds favor national health insurance. So we need a plan where people feel there is a major government role, with strong private sector involvement. Otherwise, we just won't get it.

One problem is that fewer people today believe the government can do anything competently (Chart 11). That's the politics we live with. We can see this lack of confidence when we talk about how to finance national health insurance (which 72 percent of the American public favors). The bulk of the people are within the $100-150 tax range for acceptance.

Table 2

Public Preference for Financing an NHI Program

In rank order of preference:

1. Excise taxes
2. Employer tax
3. Social Security tax
4. Premiums paid by the uninsured
5. Sales tax
6. Income tax

Recall from Chart 5 that when we ask which tax do you hate the most, it is the income tax, along with the property tax. The public likes the state tax

because it is flat, and one-third of the states don't have a state income tax. We asked Americans how they would finance national health insurance (Table 2), and the answers in this order were excise taxes, employer taxes, Social Security, premiums by the uninsured (Americans believe insurance should be compulsory), sales tax, and income tax.

We have to get Americans off this—the idea that it is someone else's burden. It comes back to the employer. The polls show Americans do want employer contributions—for health care, for day care, for parental leave. But employers don't want to give on health care because it opens the door to the other work place benefits.

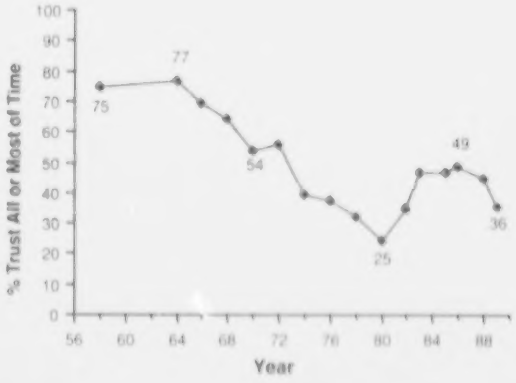
As we have seen in Chart 7, there is strong public support for spending more on health care—the public thinks we spend too little. The public is also against unreasonable doctors' fees and hospital charges. But as soon as there is a fiscal crunch, public assistance is the first to go.

Further, since only one-third of Americans believe in the leadership of Congress, and Congress knows it cannot win the trust of the public with its national health care plan, the public seems to be waiting for a private sector plan. Because Americans tend not to trust people who lead institutions, they form their opinions after reading the newspapers. How newspapers frame the issue in the debate on national health care will affect the way the public thinks. For example, on the catastrophic act, newspapers talked about the "new tax on the elderly." How the press frames national health insurance, therefore, is critical. It will be "Will You Wait for Years to Get Elective Surgery?" and "Will You Be Able to Get the Doctor of Your Choice?" or it will be "Is Your Employer Going to Be Allowed to Cut Your Benefits in the Future?" The media will decide the issue.

The debate is about to happen. Labor and higher education can play a major role in shaping it. But we have to understand the public's attitudes before we get in the middle of it.

Chart 11

Americans' Trust in the Federal Government to Do What is Right 1958 - 1989



"What I tell American physicians and hospital officials and what I want to tell you is that unless we figure out a way to make the financial stability of this system more equitable, fairer, and most importantly, more stable, it is hard to imagine our health care system continuing much longer."

IS A RADICAL CHANGE IN HEALTH CARE FINANCING FOR THE UNITED STATES IN THE OFFING?

Stuart H. Altman
Dean, Heller School of Social Welfare, Brandeis University

I agree with Bob Blendon when he says that we are in a mess, that the American people are fed up, and that our health care system is valued the least by our populace when compared to that of other industrialized nations. And I come down even harder. The problem is not that we don't love our doctors, or our hospitals, but we're financially scared. It is this economic pressure on us that makes us react the way we do.

What I tell American physicians and hospital officials and what I want to tell you is that unless we figure out a way to make the financial stability of this system more equitable, fairer, and most importantly, more stable, it is hard to imagine our health care system continuing much longer.

I am reasonably sure that when the federal government comes up with the statistics, we'll not be at 11 percent of GNP for health care, but at 12 percent of GNP. We'll not be at $660 billion, we'll be way over $700 billion. Now, if $660 or $700 billion a year doesn't excite you, maybe $1.5 trillion or $1.8 trillion by the end of the decade will. The point is—you look at these numbers and you say, "My God, how can we continue to function much longer in the way we are functioning?"

The message I bring to you is that there are limited periods in our history when change can take place, when we can really do something. It requires two things: (1) a serious problem and (2) leadership. It requires recognizing the problem and moving on it. And the last time we had that serious problem and we thought we had leadership, we failed. That was 1974.

The Failed 1974 Drive for National Health Insurance

Let's talk about the period leading up to the 1974 problem, and then come back to where we are today. To me, it seared in my mind a set of lessons we don't want to repeat.

The Mid-1970s Context—When we came out of the 1960s, we were all excited. We had passed Medicare, stage one of a true national health care system. We were going to move through the system. The trade union movement was out front, both in Medicare and in moving forward.

Walter Reuther of the UAW chaired the "Committee of 100" which prepared the blueprint on how we were going to take the next step—the restructuring of the financing system of health care. The federal government, through a series of tax systems, would finance it. We would get rid of the inefficient insurance system, pull together a truly equitable financing system, and create a delivery system that made sense.

Out of that came a bill which Senator Kennedy championed in 1971. Every major group involved in health care, including the AMA and the American Hospital Association, the equipment manufacturers association, the Blue Cross, the insurance industry—everybody was at the table fearful that they were going to be tarnished with the brand that the AMA

was tarnished with during the Medicare movement—of not being progressive and supportive.

Every organization came up with its own plan during the 1970s. The Nixon Administration, interestingly enough, also wanted to be at the table. It came up first with a Mickey Mouse, squeaky plan to do a little something, and then in 1973-74, it offered a much more ambitious plan which became known as the Comprehensive Health Insurance Plan. Here we were, everybody out there with a major piece of legislation to transform and create national health insurance of some form in this country.

The experts of the day said, "It is no longer a question of whether we will have national health insurance, the only issues are what kind and when. I was young, naive, and in the position of Deputy Assistant Secretary for Planning and Evaluation at HEW. Here I was, in on the creation of a National Health Insurance System for this country.

The Nixon Administration Signs On—I watched what happened in 1974, and it really set me back. This is my sense of what was happening. The Nixon Administration, surprisingly, with his Secretary of HEW Casper Weinberger, put forward a quite liberal, comprehensive piece of legislation. Senator Kennedy and Representative Wilbur Mills, Chairman of the House Ways and Means Committee, saw that the Administration was serious and put together a bill along the same lines.

It appeared in the spring and early summer of 1974 that we could really develop something. In July 1974, Wilbur Mills announced to the Ways and Means Committee that we'd already had hearings on the bill, and that he would go right into Executive Session and pass the legislation. However, looming on the horizon was Nixon's impeachment. Perhaps, had he not resigned, we might have had national health care insurance.

The Unraveling of the Plan: Personal Interests Prevail

Anyway, everyone was very active and involved. They all sat down to debate. As the debate took place, all of the key groups, which incidentally were reasonably if not very well insured, sat down, each bringing to the table its own preferred plan.

However, their backup plan turned out to be the status quo. Negotiations are serious business, as you trade unionists know, and it requires give-and-take. But this set of negotiations had a very different set of characteristics. What it came to was, "Here is my plan, and I am prepared to make some minor changes"—from the AMA, the insurance industry, the AHA, the employer groups, and labor. Labor also laid out its options, and there was very little give. Each negotiated, but not seriously.

When it came to the final votes, each of the groups said, "My plan or nothing"— nothing being what we had. The people sitting there were well covered by insurance. The people who were not in the room were the uninsured and the half insured—the people who would ultimately not be insured.

At this critical time, the window closed. It just hit. Maybe, in hindsight, everyone will say we didn't anticipate in that summer of 1974 that the window would close so abruptly. We also didn't anticipate that Wilbur Mills would come in for personal embarrassment and lose his power, that a new president

Dr. Stuart H. Altman, Acting President of Brandeis University and Dean of the Heller School of Social Welfare

"I say to the business community, you are now paying for your workers and their spouses, but also for the uninsured, the underinsured, and the Medicare/Medicaid shortfall."

would come in and not have the same commitment to national health insurance, and that this country would go complacent, even anti-government, as it did in the latter part of the 1970s and the 1980s. But it just went away. It just evaporated.

The Current Debate: Someone Pays

So here we are, 16 years later, with the number of uninsured growing from 15 million to 37 million, with the percentage of our GNP going from 8 percent to 12 percent, and with a new "ponzi game" which has been created called "cost shifting"—almost an art form where every major player figures out some way of giving it to their neighbor.

I'm involved directly. I chair the government's Prospective Payment Assessment Commission, responsible to the Congress and to the Administration for overseeing how Medicare pays hospitals. And we are determined to cut the toughest bargain we can with respect to how Medicare is going to pay hospital bills. We are about to do it, and we can play tough. We know how to do it.

But hospitals turn around and sock it to someone else. And the "someone else" has become big labor, big business, and big universities. I tell American business that you have become our government. Look at what you are doing—good, conservative, mid-west Republican business leaders. You think you are big, strong, and into competition and managed care, squeezing out inefficiencies in your system. You work very hard at reducing costs 3 percent, 5 percent, or 7 percent, and the most efficient by 10 percent.

Then I come along—big government with Medicare—and we pay 80¢ on the dollar, 70¢ on the dollar, 60¢ on the dollar. Guess what happens. You get stuck with a 20 percent add-on to your health care bill. What's happening—you save 5 percent by cost cutting, we've added 20 percent. The net impact is that you lose 15 percent.

I say to the business community, you are now paying for your workers and their spouses, but also for the uninsured, the underinsured, and the Medicare/Medicaid shortfall. And you will continue to do it. You know that—you cannot stop it. There is no amount of Adam Smith and the competitive forces you can bring to bear to stop it. It is not possible. You're playing with only part of the deck, with the government controlling more of the deck than you do. You need to think differently.

More and more I thought they would listen to me, that they would eventually realize that the only way to solve the health care problem was to bring everyone under the same tent.

Somewhere along the line, we would figure how these competitive forces—between government and business, between big business and little business—are counterproductive. No one is going to win.

I'm not for an all-government system, but we need some structure that brings us all together. A few years ago, I thought we could solve this problem. We could work it out together. But, alas, I'm as frustrated in 1990 as I was in 1974. I see the same game playing out.

I was part of a private sector coalition of business and labor groups, and we came out with a plan—a private sector component, an amalgam, a

good American plan. We thought we had consensus. We even changed the wording to please the AMA and the insurance industry, and worked on cost containment to keep big business in. We worked hard for the labor movement.

After the group finished its task, the AMA says, "This is un-American and not acceptable. You have too much cost containment, too much regulation," and they picked up their papers and walked out. Then the insurance guy gets up and says, "With the way you've organized this system, we are going to lose 50 million Americans." What he didn't say was that these 50 million are in firms they don't insure anyway. They are 50 million "potential" customers who would now be part of a government plan. They walked out. The head of IBM says, "Not enough cost containment." We said, "AMA left complaining of too much cost containment." Organized labor stayed in—to its credit. It all just slid away.

Take President Bush's Administration. Of the 10-15 problems on the President's desk, health care is 17th. That's crazy. They are not serious about health care reform.

What Has to be Done

What is it that we have to do? What has to happen? We have taken the art form of private insurance experience ratings and pushed it to the nth degree. In the new world, they can predict when you are born with a gene out of balance that you might contract a serious illness at age 47 or 62. You may not be able to get health insurance. We now have individual experience ratings, formerly known as community ratings, representing a tightening up.

Elaine Bernard, Executive Director, Harvard University Trade Union Program, presiding at Dr. Altman's presentation.

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"As long as somebody is standing atop our health care system with two buckets filled with money, and is prepared to pour as much money into the system as the system will handle, no amount of trying to control the spigots will work. You have to control the buckets."

We have a financing system that is crumbling, a health care cost problem growing at two times the growth of the GNP, and cost shifting that is pushing costs increasingly to the private sector. And yet we have no leadership in Washington. Each group is looking at its own set of issues and deciding what is in their interest.

In 1973, I thought I knew the answer. I didn't believe we would let that period go without solving the problem. I hope we don't do it again. Ultimately, the people who are losing are the 37 million uninsured (and the figure could jump to 50 million), and another 20-30 million just above it who are paying 28-35 percent of their income for health care insurance. We can't afford to let it go much longer.

Unfortunately, there are only two choices, other than the crazy-quilt system we have now. One is a totally government-financed system, the other some combination of employer-based system plus increased government financing. These are the only two choices that can be truly comprehensive.

Many of you strongly favor a government-financed system. I could live with it, but my sense is that it will not happen. Government's ability to finance the system alone is very unlikely and people are willing to pay small amounts in increased taxes, but not enough. I believe our best hope is for some combination of a government-financed system with a private insurance system.

We need a new financing system that guarantees equality and financial stability, and a tough cost containment system that works. We need goals—a limit on the percentage of health care spending in the GNP.

As long as somebody is standing atop our health care system with two buckets filled with money, and is prepared to pour as much money into the system as the system will handle, no amount of trying to control the spigots will work. You have to control the buckets. Every country in the world that controls health care spending controls the buckets—the flow of money into the system. You can't control it after the money is spilling into the system. Piecemeal approaches, with everyone trying to control their own spigot, won't work.

Business thinks it can control its own spigot—forget it. If government thinks it can control its own spigot—it won't happen. Control both sets of spigots, and control them together.

This is a critical time. You are leaders in higher education and the labor movement. We need a comprehensive plan which can only come with us working together. I believe American business holds the key, but it seems unwilling to do it. The labor movement is willing to compromise, and wants to make it work. I don't sense it with business yet.

More and more corporate people know we need reform, that government has to be involved, but they haven't come together.

Washington is not going to lead. The president isn't there, Congress isn't there. The issue needs leadership from the bottom up. This president or this Congress will not act unless they feel strong public support for their actions. They are still licking their wounds from the catastrophic insurance fiasco.

We have to solve this problem, and solve it fast. There are no ideal plans, no simple solutions. It will be a uniquely American solution.

2. Labor-Higher Education On Health Care Reform

Panel Presentations

LABOR'S PERSPECTIVES: THE NEED FOR HEALTH CARE REFORM

John J. Sweeney
President, Service Employees International Union

I am pleased to be at the Council's Annual Meeting as health care reform is the key political issue of the 1990s. It is a complex, emotional issue. It touches the deepest fears of individuals and is our toughest political issue as a society. Even though our politicians tend to avoid complex problems, they'll have to deal with this one before long.

Health Care Reform as a Dominant Issue

Health care is a volatile issue. The 37 million uninsured are beyond our reach. We have a health care cost crisis which is not going to go away by itself. We learned from the 1980s that health care markets are not self-correcting.

We face accelerating erosion of employment-based health care coverage, traditionally the backbone of health care financing in our country. For example, the cost of health coverage to employers is climbing at four times the general rate of inflation with no end in sight, and institutional leaders and managers are responding to that cost pressure with increasing exasperation, as we have heard today. They are redesigning their benefit plans. They are trying to push the risk of rapidly increasing costs on to their employees, and many employers are getting out of the health business altogether by hiring more contingent workers, part-time workers and temporaries, and contracting out work. None of these workers gets any benefits.

Universities are not exempt from cost pressures plaguing employers, and neither are they exempt from the short-sighted management tactics we are seeing across the bargaining table in far too many situations. At Brown University today, SEIU members are currently on strike over health care issues. In fact, health care is the number one issue in labor-management problems today.

This isn't the first time we've seen double-digit premium increases. In the early 1980s, labor and management pioneered innovative cost containment as a way to protect benefits, while moderating the cost impact on employers. Today, many of these techniques are being refined and repackaged as "managed care." But let's not kid ourselves. We've saved what we could through cost containment devices, and now we're up against the causes of health care inflation which are just too big and too complex to be solved plan-by-plan or employer-by-employer.

For example, we're up against cost-shifting from the public to the private sector caused by providers charging private plans above costs because public programs like Medicare pay below costs.

The new federal budget includes $32 billion in savings from reduced payments to providers. Every penny will show up in increased charges to private plans. Then there are the companies that provide no health insurance for workers. Responsible employers

John J. Sweeney, President, Service Employees International Union

"We hear so often that America has the finest system of health care in the world, which is probably true — if you have enough insurance."

pick up the tab through family coverage plans and higher charges on our hospital bills.

New Jersey collects over one-half billion dollars a year for this so-called "uncompensated care" through insurer surcharges on hospital bills.

Then there's the growing administrative costs which a recent study pegs at 1/3 of the total health care costs. Doctors, hospitals, and insurers are all pushing rising mountains of paper. There's also the waste in the system. And the evidence seems conclusive that physicians perform large numbers of unnecessary tests and procedures.

Erosion of Employer-Based Health Insurance

The roots of health care inflation are beyond the reach of labor or management alone, or even labor and management together in the collective bargaining process. That's why our employer-based system is in one hell of a mess. That's why the labor movement has concluded that a political solution is essential and that it must come soon.

The erosion of our employment-based health care insurance system is having a visible impact on the economic health of working families. As "3rd-party coverage" and public programs grew steadily over the post-war period, the household share of health care spending declined. But in the 1980s, that trend reversed.

The burden of health care spending on working families is actually increasing. Governments are cutting back, employers are trimming benefits, and households get stuck with the tab. In health care, the family budget is the payer of last resort.

We hear so often that America has the finest system of health care in the world, which is probably true—if you have enough insurance. But opinion polls clearly show that more Americans believe our health care system needs fundamental reform than do residents of any other industrialized country.

The root of this unhappiness is the financial anxiety about the threat of uncovered medical expenses. In fact, polls show that people do not think that our country spends too much on health care. Nor do they believe that we have too much expensive, high-tech medical care. What they are worried about is their family's health coverage. Will I be covered if I get sick? What if I picked the wrong benefit option? What happens if I change jobs? These have become the regular topics in the lunchrooms and family gatherings.

Developing a Political Program for Health Care Reform

I think we are on the verge of seeing that personal anxiety converted into political outrage. Translating that outrage into meaningful reform will require leadership—leadership from the academic community as well as from the labor movement.

I hope that all of you have had a chance to see some of the AFL-CIO health care reform commercials that aired last September and October. That kind of air time is expensive, but it is a sign of how seriously labor takes this issue.

The AFL-CIO held eight regional hearings around the country in September and October, chaired by Lane Kirkland or Tom Donahue. The members of the AFL-CIO Executive Council who

are here were among those who participated in these hearings.

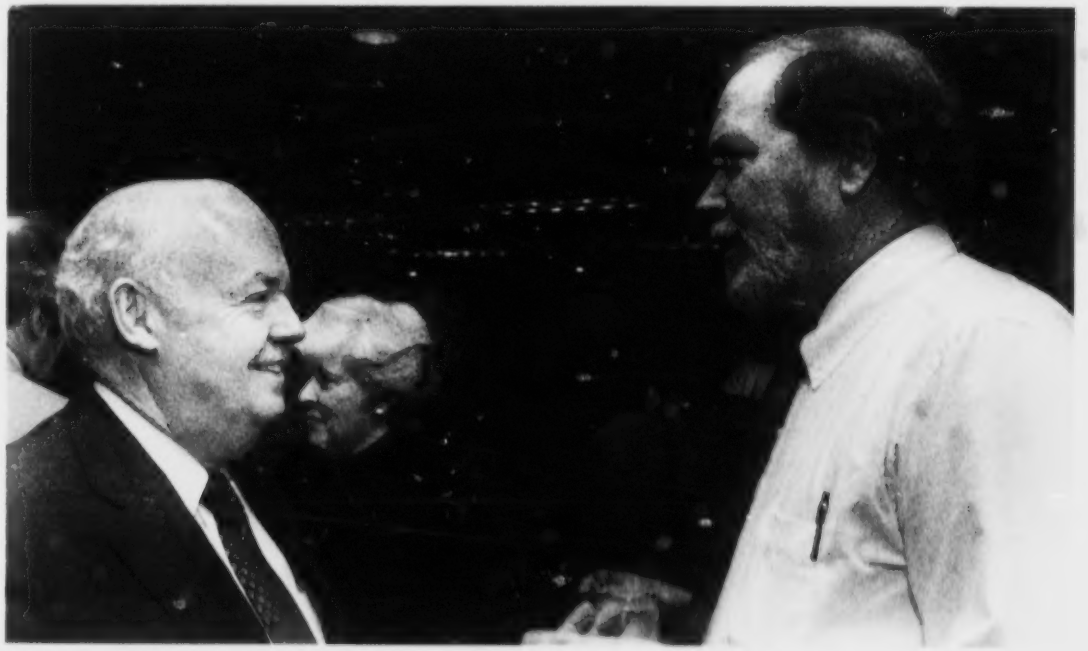
The AFL-CIO will be presenting to the nation a plan for national health care reform by the spring. We know we have our work cut out for us, but we have no choice. Believe me, the current administration in Washington is not ready to take on the entrenched special interests—the doctors, the hospitals, and the insurers.

These groups may not be any more selfish than the rest of us, but they all want to hold on to their enormous financial stakes in the health care sector—now more than 1/10 of our economy. It is killing us.

Every major industrial country, other than ours, manages to guarantee its citizens affordable health coverage through a system of universal cost containment. They employ "all-payor" reimbursement systems, capital budgets, and expenditure targeting.

One way or another, those who pay for health care—government, employers, insurance health funds—will have to get together to control the providers. Our Congress will need to make some very hard choices in order to overhaul an industry which is larger than the entire GNP of Canada.

That's why the labor movement has undertaken a national grassroots campaign to promote health care reform. It's tough going because we're telling Congress something it doesn't want to hear. We're telling them that we think that the crisis in health care, and in health care costs and coverage, is the responsibility of the federal government. Congress and the President would love nothing more than to drop the whole health care mess on the shoulders of



John J. Sweeney with Robert L. Gale, President, Association of Governing Boards

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Judith Eaton, Vice President, American Council on Education

the states. But the scale of the problem and the alarming condition of state budgets argue convincingly for a federal solution.

Of course, there are those who would argue that it is unrealistic to expect any national move on national health care reform in the wake of the budget negotiated between Congress and the Administration, but I'm really convinced that the political pundits are not reading this issue correctly. The country is moving rapidly to the point where a national consensus will be reached.

Unfortunately, the history of social policy in our country is rife with reforms that almost happened. It would be a major mistake to think that a solution to the health care dilemma will just emerge in the course of events.

The time for health care reform is close at hand. But the question is, will we be ready? Not just with good ideas. Our failure to enact national health care reform in the past was not for the lack of ideas. What we lacked in the early 1970s, and what we still lack, is a political coalition strong enough to win.

Today, the possibility exists for such a coalition, building on the foundation of an alliance of purchasers—both labor and management. I believe this meeting of the Council offers a good opportunity to talk about how we might fashion such an alliance.

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Gerald W. McEntee
President, American Federation of State, County and Municipal Employees

(Delivered by Robert McGarrah, Director of Public Policy, AFSCME in Mr. McEntee's absence)

AFSCME represents university employees at the University of Massachusetts and Harvard University, and health care is a major concern on these campuses and a major concern for the employees as well. Not only is it expensive for the students in terms of the fees they are paying, but it is getting more expensive for employees.

At the first contract at Harvard, we were able to negotiate some shifts back towards the employer, reversing some of the trends. Before the contract, Harvard was picking up 70 percent of the weighted average premiums; now we have it up to an 85 percent share. But we haven't licked the problem. Health care costs remain a major issue at Harvard.

Universities, as employers, are trying to find ways to shed these costs, to shift or share health care costs with employees. It is one of the reasons why working Americans have come to this issue, and rank it as their top concern when they are called by the public opinion pollsters. ABC News' pollster, Peter Hart, says there is no question that this issue is the top item with the public, who are waiting for politicians to seize it and move on it.

This issue affects AFSCME as a public sector union in many different ways, beyond bargaining. We represent employees in West Virginia, for example, who as a result of the teachers' strike this past year, got their pay increased from $9,000 to $10,000 per year. Then they watched as the state demanded they share that pay raise back with them in the form of increased payments and premiums for health care.

This is happening over and over again at the bargaining table, and it is happening to the point where we have a consensus at AFSCME that we should be going for national health insurance. AFSCME also runs joint trustee plans operated as part of our contract, and it is costing us more and more to run these plans.

A national health care plan would be far less costly. We should be out of the health care business, as we simply cannot contain the costs on our own. We've tried "managed care," reducing costs, and holding the line, but it isn't working, because we have such a fragmented system in our country with costs constantly being shifted.

Medicare and Cost Shifting

The federal government, through Medicare, runs a popular program for those over 65, but Medicare is widely perceived as a major program that shifts costs, because it negotiates by setting its own Diagnosis Related Groups (DRGs). It is now setting fee schedules for doctors. It is a public negotiating process, and that vehicle is increasingly appealing for employers around the country.

The extensive cost shifting affects the providers also. We represent providers—300,000 health care workers. The Medicare DRGs have meant layoffs for health care workers, short staffing, understaffing, and closure of rural hospitals. Even some of the large

"A national health care plan would be far less costly. We should be out of the health care business, as we simply cannot contain the costs on our own. We've tried 'managed care,' reducing costs, and holding the line, but it isn't working, because we have such a fragmented system in our country with costs constantly being shifted."

Robert McGarrah, Director of Public Policy, American Federation of State, County and Municipal Employees (AFSCME)

public hospitals have been hit by the changes in Medicare.

All of this points to the need for a comprehensive restructuring of our health care system.

The States Under Duress

We also represent public employees in state and local government. Our concern is that Medicaid mandates are increasingly being shifted to the states and are swallowing up the state budgets. The National Governors' Association and some of us in the public sector actually opposed a proposal from progressive Democrats to expand Medicaid eligibility for children in poverty up to the age of 18. The states said this move would cost them $3 billion from fiscal 1991 through fiscal 1995. This would be in addition to the $2.5 billion they will need for the additional mandates passed for fiscal 1991.

The governors want to see a fundamental national restructuring of health care. With Medicaid costs increasingly being shifted to the states, every CEO is coming to recognize that health care costs are not containable in one health insurance plan. You've got to be able to cap the overall expenditure in health care and restructure the system.

So the governors want to see a fundamental system reform and are working on several approaches and looking at options. They oppose expansion of Medicaid because it is killing them on their budgets, especially in the face of a full-scale recession. We're getting serious layoffs and a slowdown in contracting to the private sector. New York, for example, can't raise taxes to cover these Medicaid increases, so it will have to cut Medicaid.

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There's also bad debt and charity care, with cities running public hospitals for the poor and getting stuck with bad debts and charity care. From all of this is coming a great demand for restructuring the health care system.

Restructuring the Health Care System: Starting in the States

We spend more than any nation on Earth on health care. We have the funds. So how do we get the necessary restructuring?

We at AFSCME have gone through an intensive examination of this issue with our members, and we have decided as a union to work on this issue in the states. We think we can leverage national health care reform in that way. The forerunners of Social Security came out of the states. States are laboratories to begin to develop a consensus. Washington isn't likely to move on national health care reform as a priority, but we can stimulate action from the states.

The Single-Payor Approach

The other critical point is that we think we can carry out a fundamental reexamination of the system to look at the advantages of reducing and limiting the number of insurance carriers--in effect, looking at the advantages of a single-payor system. This would not mean a complete adoption of the Canadian system, but examining and eliminating the administrative waste and overhead in claims processing and other administrative chores that go on in insurance in America.

It amounts to $75 billion of waste that we don't need. Studies indicate we could take that $75 billion and apply it to a single-payor system and expand coverage to all the uninsured. That's a fundamental change.

The AMA rails at rationing in Canada, but they don't speak to the woes of 37 million who are uninsured and the additional 50 million who are underinsured or fearful of losing their coverage.

What would it mean for labor if we went the single-payor route? With a single-payor approach, we would be aiming at that 46 percent of the public who believe there should be a government approach to the issue. Lane Kirkland, President of the AFL-CIO, has said that labor is in a negotiating mode on health care reform. So we want to see reform happen in the 1990s. We will not stand on a bunch of principles that will not get us there. We'll make the kinds of negotiations that have to take place, but we want to lead and start from the best approach.

At AFSCME, we have made that decision, and we think the single-payor program is the best one to move forward on. We're working diligently with our brothers and sisters in the AFL-CIO and with President Sweeney and the AFL-CIO Health Care Committee, and we think we will come out in the next several months with a plan for organized labor. We hope to work with you to see that it is realized.

"So we want to see reform happen in the 1990s. We will not stand on a bunch of principles that will not get us there. We'll make the kinds of negotiations that have to take place, but we want to lead and start from the best approach."

W. Ann Reynolds, Chancellor, City University of New York

Panel Presentations

HIGHER EDUCATION PERSPECTIVES: THE CAMPUSES AND HEALTH CARE CONCERNS

W. Ann Reynolds
Chancellor, City University of New York

New York City's health care system is in a state of crisis, and that fact affects the City University both directly and indirectly. For example, through November, 1989, Boston had 1,929 total reported AIDS cases. Los Angeles had 8,079. New York had 22,573. The average length of stay for hospital patients in Boston in 1988 was 8.1 days. In Los Angeles it was 6.5. In New York it was 10. We also have more homeless people, more drug abusers, and more low-income people than any other city, and many of those people, when they get sick, remain hospitalized beyond the acute-care period simply because they have no other place to go.

The result is that we have a severe bed shortage—you hear stories all the time of people being turned away from hospital after hospital or waiting months for elective procedures—and an even more severe shortage of personnel. By necessity we're holding costs down: The American Hospital Association reports that labor expenses per in-patient day are about $380 in New York compared to $549 here in Boston. But we're paying for that forced efficiency by diminshing the quality of care.

Even so, health care consumes a greater and greater share of the public sector budget and makes it much more difficult for us and other public institutions to function effectively. So the health care crisis is our problem as much as anyone else's.

We really have three related problems: inadequate supply, excessive demand, and insufficiently coordinated analysis of the system. Universities in general, and public universities in particular, including my own, can help in all three areas.

Inadequate Supply

We have 200,000 students at 21 separate campuses across the City. Most of them come from low- or lower-middle income families, and most say the reason they're coming to college is to make more money or to get a better job. We hope they get something more than that along the way, but that's the initial motivation. Except for international students, almost all of them come from the metropolitan area, and almost all of them want to stay in New York after they graduate. Most of them are already working, generally in relatively low-paying jobs. This is a population that's enormously sensitive to the realities of the local job market. They make their decisions about majors on the basis of where the employment opportunities are, and a vast proportion of those opportunities are in health and allied professions .

So it's no surprise that vast numbers of CUNY students decide to major in health-related areas, and a very large proportion of those are minority. We are making a major contribution to the resolution of one of the country's continuing problems, which is the

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non-representative nature of the medical profession in the highest-status positions of that profession. We will also provide in-service training on a non-degree basis to 25,000 people in health fields in our affiliated medical school.

Do our activities resolve the personnel-shortage crisis? Obviously, no. Today there are hundreds of unfilled positions in New York's hospitals and related facilities, with a vacancy rate just for nursing of about 39 percent. The heart-breaking paradox is that people who need care can't get it in a city where thousands more would like to be working as care providers. It cries out for remedy.

We are expanding existing programs and developing new ones, and as our budget takes one cut after another, we're trying to garner as much external support as we can. Some of that support comes from the labor community. For example, an evening and weekend degree program in nursing is in place at the Borough of Manhattan Community College, with more than 300 students enrolled. Almost all work full time in low-paying and lower-skilled health care jobs, many of them as nurses' aides. The overwhelming majority are minority women and most have families to support, so they can't stop working in order to go to college. The program involves two or three hours of classes three evenings a week and six hours on Saturday. After two years they get an Associate degree; eventually they will be able to continue in the evening and weekend program pursuing a baccalaureate degree in nursing. They will be able to move from the secondary labor market to a career track where they can help meet a critical community need.

Funding for the nursing programs comes from the Aaron Diamond Foundation, the Altman Foundation, and District 1199 — the hospital workers' union. The union role is critical. They were involved in the planning and development of the program from the start, and we rely on District 1199 and AFSCME District Council 37 to publicize the program and recruit students. Union representatives serve on our Advisory Committee, and we provide basic skills instruction and tutoring at the unions' headquarters.

The nursing program is a model, but we are now at the point where we need state operating funds to continue and expand it. However, we have been told that those funds might not be available. This gives you a sense of our opportunities as well as our constraints.

The Demand for Health Care

On the demand side, CUNY's primary assets are access and visibility, and we're seeking to exploit both. We have a direct line of communication to our 200,000 students. We run day care centers and elementary and high schools, community programs, even a television station—and those things bring us into the lives of 8 million New Yorkers. With the possible exception of the public school system, no institution in the City is better able to play a major public health role.

That role has many facets, ranging from immunization, where we are complying with the law and making sure all CUNY students are immunized, to nutrition in our day care centers, to activities for the aging. There is one special area, however, where

"...health care consumes a greater and greater share of the public sector budget and makes it much more difficult for us and other public institutions to function effectively. So the health care crisis is our problem as much as anyone else's."

Dorothy Shields, Director, Department of Education, AFL-CIO, Len Oliver, Executive Director, Labor/Higher Education Council, and Joseph Duffey, President, University of Massachusetts at Amherst

universities have a primary role to play, particularly in metropolitan areas.

I'm talking about AIDS. There are 12 million college students in the U.S., and 80 percent or more are sexually active. Though up to now the highest age category for AIDS cases has been 30-39, the lastest data reveal that people in their 20s are not far behind. A study for the American College Health Association and the U.S. Centers for Disease Control indicates that two of every 1,000 college students are HIV positive (higher in New York). This means that 24,000 college students, most of them sexually active, are infected with the AIDS virus, and most of them don't know it yet.

Our obligation is to guarantee that every man and woman on campus—and most of the people in the larger community—understand the risks of AIDS and know how to minimize those risks. So our role is primarily educational.

Coordinated Analysis

There are only three real sources of expertise in the health care area—government, the foundations, and the university, and I think we are the more important. Indeed, it is through us that government and the foundations do most of their work.

For example, our economists are dealing with issues of cost-benefit, social workers are researching alternative models of delivery, philosophers are looking at the "Who shall live?" questions. People affiliated with CUNY have pioneered in the area of health care and gender, the economics of Medicare and Medicaid, and other structural issues. That's an important role for the university.

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We all look forward to the day when our country has a rational, affordable system of national health care. We want to see a society that's conscious of the environmental impact of economic choices and that focuses on prevention as well as cure. We want to see an America where people of all backgrounds have access to quality care when they need it—provided by well-educated and well-compensated men and women. The health care crisis is a dilemma for the academy and for labor. Nothing is more complex, but in no area is a concerted, aggressive response more vital.

Joseph Duffey
Chancellor, University of Massachusetts at Amherst

Boston is a city where a black child has less chance of living through the first year of life than a child in North or South Korea. That says something about America's priorities. The city and the region have enormous resources in medical care and technology, but we find that 85 percent of all expenses for health care in our region, and maybe in the nation as well, are devoted to the last two years of life.

Massachusetts has cut back its expenditures for child nutrition, and I have long felt the single, most important investment in health care is the nutrition of our children. Our issues, your issues, America's issues in health care are obviously access, affordability, and who will pay, along with values and priorities and how we will address them.

Let's move to my university. There are two ways in which the question of health care is a continuing and increasing concern at the University of Massachusetts at Amherst. We have a rural campus, with 25,000 students and 6,000 employees, so we have to maintain a major health center.

We finance the health center through fees, because there is no support from the state. That fee obviously has been the fastest growing fee on our campus over the last decade. It's a wonderful health care system, with quality, breadth, and comprehensiveness in the services provided. We have clinic, outpatient, and educational programs with referrals. We require students who don't have major health insurance for serious hospitalization to buy insurance—an increasing burden for them.

We also give a lot of attention to health education. About 80 percent of the serious illnesses in America relate to life style—abuse of alcohol, drugs, smoking, diet, and lack of exercise.

So the University of Massachusetts at Amherst runs this clinic and facilities with extensive educational programs on health care and substance abuse. The clinic also functions as an HMO, providing some services for the larger community.

Our employees and faculty are increasingly faced with the question of making larger contributions to the costs of premiums. Consider that in 1990, just the incremental cost of Medicaid in Massachusetts is greater than the expenditure for all of higher education. In the next couple of years, we will have debates on redefining eligibility and increased copayments for public employees. On our campus it is by far the largest fee our students pay.

Health care costs are becoming increasingly prohibitive for us, and for similar campuses across the country.

"Health care costs are becoming increasingly prohibitive for us, and for similar campuses across the country."

3. VALUES & OPTIONS FOR HEALTH CARE REFORM

Lenore Miller, President, Retail, Wholesale and Department Store Union

Robert J. Pleasure, Executive Director, George Meany Center for Labor Studies

Work Group Reports - A

A. Leader: Lenore Miller, *President, Retail, Wholesale and Department Store Union*

Resource: Ann Marie Hendricks, *Deputy Director, Program on Health Care Financing and Insurance, Harvard University School of Public Health*

Reporting: Robert J. Pleasure, *Executive Director, George Meany Center for Labor Studies*

Our group considered the AFL-CIO principles with some care and tried to order them in priority by clusters, making certain language modifications to the principles.

Cluster number one is Universality and Fairness, the AFL-CIO's first principles. Universality seemed to parallel fairness, and we believe the two should be consolidated. We agreed that the language under fairness, which "assures that the unemployed, the poor and their dependents have affordable access to health care serices," was really subsumed under the notion of universality. Why do we need to separate out the populations of the U.S. in a statement of principles? Why say we are doing this particularly for the poor and their dependents, since everyone should be covered by the twin principles of universality and fairness?

Cluster number two included Affordability, Accessibility, Portability, and Comprehensiveness. It made sense in reordering the principles to bring all of these together. But we had certain concerns. Should we, in the context of "affordability,

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accessibility, portability, and comprehensiveness," refer to "basic benefits?"

We don't want to scare anyone off by suggesting a new set of benefits that go beyond anything that has been negotiated for the work place, but our consensus was that the notion of a "comprehensive set of benefits" already is the principle, so we opted not to refer to "basic benefits."

A question was raised about portability. The language about portability guarantees all Americans, "regardless of where they live," the same package of benefits. In common usage, that doesn't appear to be portability. We think the substantive problem is U.S. nationals in international travel, or travel into the U.S. by foreign nationals. Our consensus was that Americans ought to be covered whether here or abroad, as well as non-citizens who happen to be in the U.S. The Canadian system provides this coverage.

So under portability, we would eliminate the language about "all Americans," and incorporate the concept of "all persons" and total comprehensiveness within the borders of the U.S. Externally, U.S. nationals on travel would be covered.

The other items in the AFL-CIO's list of principles appeared to be more administrative ideas, like equitable and progresive financing, public/private administration, and cost containment. We thought they should be presented separately, rather than as general principles for a national health care system.

On several issues, we could not reach consensus. The group raised good questions, such as the issue of "freedom of choice," which some think should be included. Other principles concerned "maintenance of effort," like the Taft-Hartley programs—would they be reduced under a national health care plan? Those who spoke on it thought there should be a consistent level of benefits maintained under any plan.

Another suggested principle is the relationship between the physician and the patient. We seemed to agree that nothing should interfere with the confidentiality and nature of the relationship between doctor and patient, and that this should be part of the general principles.

One issue on administration we discussed was geographic and qualitative differences, for example in rural or isolated areas. What kind of principle would realistically deal with differences in medical services for these areas?

Choices for National Health Care

Our group approached the issue of options for national health insurance by what we would recommend to the plenary. One important action would be that these general principles be presented by the Labor/Higher Education Council, or by the AFL-CIO for adoption by the ACE as well.

We would like to see increased cooperation between labor and the academic community for the generation of ideas, research, and credibility—in any coalition that is formed.

We also discussed widening of the distribution of the proceedings from this meeting to include groups like the Association of Health Services Research, the Public Health Association, the Association of American Medical Colleges, the

"We would like to see increased cooperation between labor and the academic community for the generation of ideas, research, and credibility - in any coalition that is formed."

Ronald E. Beller, President, East Tennessee State University

J. Richard Block, Vice President for Planning and Liaison, Hofstra University

Council of Teaching Hospitals—getting beyond individual doctors and hospitals and their trade associations.

We believe the Council should share these ideas broadly, and that the Council should appoint a liaison to work with the AFL-CIO Health Care Committee while attempting to bring together the broadest possible coalition.

Work Group Reports - B

B. Leader: Ronald E. Beller, *President, East Tennessee State University*

Resource: Howard Newman, *Dean, Graduate School of Public Service, New York University*

Reporting: J. Richard Block, *Vice President for Planning and Liaison, Hofstra University*

Our group endorsed the principles for national health care proposed by the AFL-CIO. However, we found no reference to the concept of prevention. The principles didn't seem to cover the total health care package, as they are more directed to an "illness-care program." Health care should go beyond that, with consideration given to prevention and consumer education. The goals are admirable, but the real task is not just to deal with the principles conceptually but to get the American public to deal with them realistically. How do we develop the values which could lead to the kind of coalition which might permit political influence on the problem?

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One job is to convince the American public that if they are satisfied with the medical services they receive, that they will not lose that sense of satisfaction if the system changes. There will be similar concerns among the health care providers with a new system, and they will have to know what is in it for them if they are going to buy in.

Another question we addressed is the concept of universal. Does it include the problems of people who are "uninsurable"—a high risk individual who could be rejected by insurance companies?

There are other major cultural values which we must recognize and consider in any health care system, including:

- "pluralism" in terms of the right to choose;
- the recognition of health care as an "investment," much as most Americans perceive education as an investment; and
- the ethical dilemma of dealing with the cost benefit of prolonging life by extraordinary means.

These are some but not all of the values we addressed. Other issues that we must keep in mind were as follows: We should address the issue of physicians believing they have to protect themselves against over-prescribing tests. For example, how does insurance and the legal profession come into this problem? This is clearly a part of cost containment.

We have to consider the impact on health care providers, and the misuse of DRGs in limiting them in providing what is considered appropriate care.

Another idea we discussed was getting the public to view the health care system as somewhat analogous with the way we deliver "utilities." We tend to be rather satisfied with the way utilities are delivered to our homes. We also know the systems are highly regulated, yet employees in utilities tend to earn reasonable wages—a model which we might emulate.

There was also recognition in our group that much of the problem of health care costs is in the high administrative costs. Part of the problem may lie with the government itself.

We made the point that we should probably stop talking about "the Canadian system." We know what it is, so we should talk about specific components of the system for our country, including such factors as freedom of choice and ethical values in prolonging life.

We then agreed upon 10 principles for a national health care system:

1. Access should be equitable.
2. Services should be of high quality.
3. Services should be provided efficiently.
4. Services should be affordable.
5. Services should be adequate.

"There was also recognition in our group that much of the problem of health care costs is in the high administrative costs. Part of the problem may lie with the government itself."

"We need to do something to raise the consciousness of public leaders to the crisis in health care. All the public opinion polls say the public thinks there is a crisis, but people who deal day-to-day with legislators don't feel the same sense of urgency. The government can move, if spurred."

6. Service providers' economic interests should be protected, and we should recognize that health care represents a major source of employment and a large factor in our GNP.

7. Any national health care system must be a rational system, not market driven.

8. There must be a minimum foundation of services.

9. We should broaden the notion of health care to include prevention and education of consumers.

10. The system should be simple to administer.

Choices for National Health Care

On looking at choices for national health care reform, we came up with several proposals that seem critical to us:

1. Can we get health care taken out of the welfare system? If health care is a right, it needs to be taken away from the notion that there are "undeserving people." It seems those who are uncovered or under-covered for health care are not undeserving, and we should shake that mentality. We need a strategy to achieve what we all seem to agree is the need for a broad-based, minimum quality health care system. We don't seem to have such a strategy now. If there are "caps" for funding, and we establish minimum standards for health care, it seems likely that the minimum would be quite low. Would it be necessary to have significant income to get quality health services? We may also have to have specialized centers for more advanced treatments, with representative boards to make difficult medical decisions.

2. Perhaps we can get national health care reform launched by proposing demonstration or pilot projects of varying characteristics. We would develop RFPs to test different models for different states or areas (e.g., public only, public-private plans) and test the outcomes.

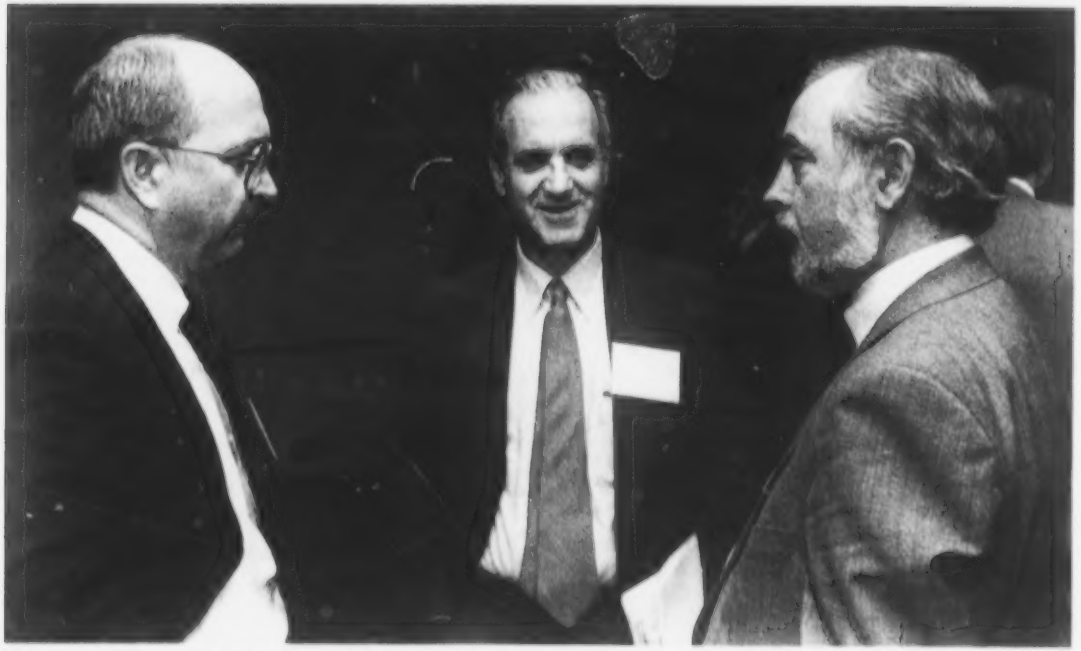
3. Are there current models, such as the Federal Highway Administration, unemployment compensation, and similar federal-state programs which might provide clues on how to obtain federal involvement, augmented by other funding sources, in a national health care program? Are there ways to derive some of the more successful components of these models, whatever their weaknesses, and apply them to health care systems?

4. The main question is who is going to pay for the services we all agree are desirable? Also, how are we going to pay for coverage for the uninsured? Is money already available in the system in such areas as improved administration to reduce overhead costs, or a willingness to limit the freedom of choice in health care? Will

Americans ever accept such limits in choice for themselves, even if they accept the concept in general?

5. We need to do something to raise the consciousness of public leaders to the crisis in health care. All the public opinion polls say the public thinks there is a crisis, but people who deal day-to-day with legislators don't feel the same sense of urgency. The government can move, if spurred. We need some kind of champion who will put the issue on the front burner. The public, the pollsters, the major sectors of labor, business, and education appear to be ready for change—where are the legislators?

6. Finally, all other "national systems" start with a maximum amount of funding for health care. The Canadian system, for example, has a fairly substantial "private" component, with some service providers not controlled by the government. Can we establish a means of adopting some of the concepts from other systems, while recognizing that they cannot be directly imported as a result of cultural differences? How do these other national systems of health care determine how much support will be available for the public?



Del Weber, Chancellor, University of Nebraska-Omaha, Peter Eckstein, Michigan AFL-CIO, and Geoffrey Bannister, President, Butler University

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Edward J. Liston, President, Community College of Rhode Island

Edward Casey, Executive Secretary, Rhode Island Federation of Teachers

Work Group Report - C

C. Leader: Edward J. Liston, *President, Community College of Rhode Island*

Resource: Gerald M. Shea, *Director, Health Care Division, SEIU*

Reporting: Edward Casey, *Executive Secretary, Rhode Island Federation of Teachers*

Our group started out by generally feeling that we supported the AFL-CIO principles. We also said that any program of national health care would include the following factors:

- a wellness or preventive medicine component.
- be a universal program that would not exclude anyone, with everyone guaranteed the right to access a certain level of medical care.
- have a consistent delivery system that addressed the notion of quality and quality assurance.

We also talked about having a more efficient use of medical personnel and facilities. Part of that discussion related to physicians' overtesting of patients, which relates in turn to malpractice and trying to control malpractice suits. It was pointed out that in some countries, the concept of malpractice does not exist.

We also talked about the streamlining of administrative overhead.

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We want to maintain strict standards of service, with a strong system of cost containment and strong regulatory mechanisms, including elimination of variations in services and standards which differ from one state to another. Everyone should pay at the same rate.

Some of our lingering questions include whether we are willing to incur the costs of continuing pluralism, which many in our group thought adds to the costs of insurance, as opposed to a single-payor system. Later on, when we talked about universal characteristics of national health insurance and centralizing of information pools, it became clear to us that you can't have pluralism and still have this kind of information pool. The competing agencies may not always be willing to share this type of information with others.

Choices for National Health Care

We spent a lot of time talking about strategies, both short term and long term. We talked about labor taking the lead in the effort, but we have to develop coalitions that would include such groups as the AARP, community-based groups, local government, the business community, and the large corporations who are really feeling the pinch of increased health costs.

We also talked about identifying up front those who appear to be some of the opponents of national health care reform—the current Administration in Washington, Chambers of Commerce, and smaller businesses who might feel they are being pushed to the wall when they contemplate the added costs for health care.

It was also brought out that if labor is going to take the lead in this effort, labor should not develop a program as "labor's program" if coalitions are to be built. Labor has to be willing to listen and to make changes to account for others' concerns.

For the longer term, we talked about educational programs at the elementary school level so people will have an understanding of health care with emphasis on wellness.

We talked about encouraging state-level activity and pilot projects that might be undertaken in states to demonstrate how a reformed health care system might work. One caveat is that if the states start to take on health care initiatives, the federal government can sit back and say let them do it. We then would not have national health insurance, because the federal government would have an excuse not to develop a plan.

We raised the issue of funding mechanisms. We agreed it would be expensive. We considered payroll deductions similar to Social Security as a means of paying for the system.

It may be difficult to sell national health insurance to those who already have health care, because they may face increased costs if large numbers of uninsured are brought into the health care system. These people, as a group, tend to be more prone to illness than the currently insured.

Finally, we said the national health care plan must include nursing homes—essentially a cradle-to-the-grave concept.

"We spent a lot of time talking about strategies, both short term and long term. We talked about labor taking the lead in the effort, but we have to develop coalitions that would include such groups as the AARP, community-based groups, and the large corporations who are really feeling the pinch of increased health costs."

Jack Sheinkman, President, Amalgamated Clothing & Textile Workers Union

Patricia A. Greenfield, Director, Labor Relations & Research Center, University of Massachusetts at Amherst

Work Group Report - D

D. Leaders: Jack Sheinkman, *President, Amalgamated Clothing and Textile Workers Union*
Jack Golodner, *President, Department for Professional Employees, AFL-CIO*

Resource: Edward Panarello, *Director, Health Care Cost Containment, New York State AFL-CIO*

Reporting: Patricia A. Greenfield, *Director, Labor Relations & Research Center, University of Massachusetts at Amherst*

Because there is overlap with the other groups, I will focus on the values and principles we felt were most important, some of which are contained in the AFL-CIO statement of principles or are implicit, or which we thought might be missing.

First, we had a consensus on the central principle of universality of benefits and universality of access. This issue of universality has to be linked to the method of financing—the burden has to be allocated equitably, and a general revenue approach is preferred.

The second principle we talked about is simplicity. Simplicity is crucial, because people will not buy into a complex, incomprehensible system. Even if it is in fact fair, people will perceive it as unfair. Examples are when people have to go through the filling out of the Medicare A and B forms. It's important that it be a simple, streamlined system.

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The third principle is that we have to work to develop a shared sense of collective responsibility, of community, and a sense of why health care reform and national health insurance are important to all of us.

We also noted that the way the concept of fairness is defined in the AFL-CIO principles tended to include only certain populations. We felt that the concept of fairness had to be broadened to be inclusive—it's everyone's problem. We have to overcome the "me" generation attitude and make it clear through education how national health care affects all of us. For example, people in their 30s and 40s may question why they need health care reform, especially if they are insured, but many are starting to care for elderly parents and starting to see the unfairness of the system. It affects all of us, not just the "other people."

Fourth, we have to convince people, based on Robert Blendon's data, that their medical service and their relationship with their doctor will not be drastically altered. We have to be sure not to destroy the individual's freedom of choice as we build a new system.

Fifth, we need to deal with the issue of prevention versus cure. We heard several examples in our group where preventive measures resulted in dramatic savings in the long run.

Finally, to accomplish all this, we must have broad-based, intensive education of the public on these issues—through the media, grassroots campaigns, and public-private coalitions. It was stated over and over again that communication is a key issue.

Choices for National Health Care

We discussed two basic issues related to options for national health care reform, and had a discussion of higher education's role in raising the level of public awareness through forums and discussion programs on structuring a national health care system.

We had a detailed discussion of the Canadian model led by Bob Kelley, one of the group's members, who had recently visited Canada. He answered many of our questions and debunked some of the myths about the Canadian system.

Ed Panarello brought in the New York State plan called "Unicare." Their focus is on centrally administered payments, administered through a consumer-labor-government-management agency with mandatory coverage and cost control. It is being used strategically, and the New York State coalition is meeting with counterparts in New Jersey and Connecticut to develop a unified tri-state approach. They believe there will be 60 congresspersons in three states invested in this sort of approach. That can be used as political pressure in terms of a national plan.

The bottom line of any national or state plan is people need assurance they will be covered for health care costs.

For higher education, we talked about how colleges and universities can work best to help educate people about the health care crisis, and what can be done about it. They can do this through conferences and workshops held through their extension/continuing education divisions and through the departments and schools. Higher education is in a

"The bottom line of any national or state plan is people need assurance they will be covered for health care costs."

Herman D. James, President, Glassboro State College

unique position to conduct public forums on national health care reform.

For example, higher education can provide an overview and historical/ contemporary context for the problem, look at alternative models, perform research on specific elements of health care, and carry out public education programs. We talked about constraints on the institutions and their faculties. And there could be grants for research that would be used in the policy debates. Universities could also establish mini-think tanks to provide information as needed in the public debate.

For the Labor/Higher Education Council, we suggest you carry out a survey on what research is going on in health care reform.* Education is critical. People have to be informed on why things have to change, and why a reformed system is needed. Education will be critical in building grassroots support for health care reform to change the system.

*The Council has received just such a survey. For a copy, write to the Council's Executive Director, Len Oliver.

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4. The AFL-CIO On National Health Care

The AFL-CIO's Executive Council, meeting in Bal Harbour, Florida, issued a statement on national health care reform on February 19, 1991. The statement resulted from hearings the AFL-CIO conducted in eight cities across the country in 1990, and discussion among the international unions serving on the AFL-CIO's Health Care Committee. The statement is designed to provide the basis for national legislation on health care reform. Since the statement coincides with the Labor/Higher Education Council's 1990 meeting theme, "Health Care Reform: America's Dilemma," the Council thought it appropriate to include the statement to further the debate on our national health care system.

National Health Care Reform

Since the 1920s, unions have advocated national reform of the health care delivery system to guarantee all Americans, from children to seniors, the right to health care.

We have supported passage of federal legislation that moves toward the goal of a national social insurance program. We have supported a requirement that all employers contribute their fair share to the cost of care. We have supported the development of a national cost containment system to prevent shifting of costs from one payer to another.

We continue to support these principles today and believe that now is the time to renew the fight for national health care reform legislation consistent with our traditional support of a social insurance system. The labor movement is united in its determination to achieve universal access, significant cost containment, quality care, and progressive financing.

The current crisis—the soaring cost of hospital care, physician services, and prescription drugs; 37 million uninsured Americans; mounting threats to the quality of health care and continued strife at the bargaining table—demands immediate action. The refusal of some employers to provide coverage has added to the cost of care for those who are insured, while millions of other Americans covered by health plans in the federal, public, and private sectors have suffered the financial burden of increased cost-shifting and reductions in benefits.

The urgency of the health care crisis for the consumers and purchasers of care and for those who have fallen through the cracks in the current system requires us to seek relief now, without compromising our principles, and to support measures that can be enacted. Such proposals would move the nation to universal access by requiring all employers, including the federal government, to contribute fairly to the cost of care. Such measures also would introduce effective health care cost containment, improve the quality of care, streamline the complex and expensive structure of our current insurance system, and advance the principle of progressive financing.

In this regard, the federal government must be a model employer and establish the standard by ensuring that its plan operates within these principles. There is also a need to address the problem of retiree health costs in the coal industry and other sectors.

We call upon all affiliates to join the Federation's nationwide grassroots campaign by mobilizing their members in an all-out lobbying effort to win national reform.

"Since the 1920s, unions have advocated national reform of the health care delivery system to guarantee all Americans, from children to seniors, the right to health care."

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To succeed in this effort, the Federation will form coalitions with consumer groups, employers, community-based organizations and providers to call on Congress for expeditious enactment of federal legislation that will:

- Guarantee all Americans the right to health care by establishing a national social insurance program that includes workers, the unemployed, and others not in the labor force and incorporates Medicare and Medicaid.
- Continue the labor movement's long-held goal of a social insurance national health care program, while recognizing that reform may come about in stages. Accordingly, we will support measures that would move the nation toward our goals.
- Establish a national cost containment program that includes a cap on health expenditures, a capital budget that manages the now-uncontrolled duplication of technology and improves the allocation of resources, and a federal authority that negotiates uniform reimbursement rates (with hospitals, doctors, and other providers) to be used by all payers.
- Create a national commission of consumers, labor, management, government, and providers to administer the program.
- Guarantee a core package of health care benefits. Supplemental benefits above the core package can be provided on a voluntary basis or through collective bargaining.
- Contain progressive and equitable financing that requires all employers to contribute toward health care coverage.
- Overhaul the existing administrative structure by establishing requirements for administrative intermediaries that would standardize claim forms, restrict the number of entities participating in the system, improve delivery of care, and assure that no individual will be denied coverage, regardless of age, income, employment status, or prior health care history.
- Reduce employment-based retiree health costs by dropping Medicare eligibility to age 60, putting the program in line with the average retirement age.
- Improve quality through the widespread dissemination of information to physicians through practice guidelines, create a national system for technology assessment, and build a national database on the cost and quality of care.
- Encourage physicians to avoid unnecessary tests and medical procedures, while developing a better system for handling malpractice disputes.
- Devise a strategy to provide all Americans access to long-term care and to make home care available to the chronically ill .

APPENDICES

A. THE LABOR/HIGHER EDUCATION COUNCIL

The Labor/Higher Education Council brings together trade union leaders and college and university presidents and chancellors along with the CEOs of higher education associations to discuss issues of mutual concern. Leaders in the American Council on Education (ACE) and the AFL-CIO agreed in 1983 to found the Council as an institutional membership organization to further understanding and joint activities between these two major segments of American society.

The Council is unique in creating a national forum for union and higher education leadership to meet in formal and informal exchanges. The Council holds a National Meeting every fall and publishes the proceedings. It also develops and disseminates joint statements on labor-higher education issues. Recent examples include a statement on the role of collective bargaining in American life and a statement on labor participation in higher education governance.

In 1990, the Council initiated a series of state-level pilot dialogues to promote cooperation between labor and higher education. It also surveyed the state labor federations to document exemplary programs demonstrating labor-higher education collaboration, and this report will be disseminated widely. The state dialogues will be expanded in 1991.

Above all, the Council will continue the invaluable dialogue initiated when the Council was founded in 1983.

Ed Cleary, President, New York State AFL-CIO and W. Ann Reynolds, Chancellor, CUNY

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"The Council is unique in creating a national forum for union and higher education leadership to meet in formal and informal exchanges."

Council Objectives

The Council's objectives are:

1. To advance mutual understanding between the American labor movement and American higher education by serving as a forum for ideas and contacts and through exchanges at periodic meetings.

2. To affirm common positions of the American labor movement and American higher education on national problems and matters of mutual interest, and—when appropriate—to engage in coordinated activity in their support.

3. To facilitate understanding on the nation's college and university campuses of the character of work in America and the American labor movement; similarly, to facilitate understanding within the labor movement of the purpose and practice of colleges and universities in American society.

4. To determine ways colleges and universities can improve their educational programs to meet the needs of the labor movement, and ways the labor movement can be supportive of the goals of higher education.

The National Meetings

The Council has held seven National Meetings, attracting between 50-75 union and higher education leaders at the annual fall gatherings. The meetings include a blend of outstanding speakers and panelists with opportunities for intensive interactions and small group discussion. Informal dialogue is encouraged. Periodically, the Council issues joint statements on important issues of mutual concern, such as its 1990 statement on labor in higher education governance which has been sent to the nation's campuses and labor organizations.

The State Dialogues

The Council, based on a directive from its 1989 National Meeting, served as a catalyst for a series of state dialogues between labor leaders and higher education officials. These dialogues took place in Rhode Island, Tennessee, and Minnesota. The success of these pilot dialogues led the Council to decide to expand the state dialogues for 1991.

Principles Guiding the Council's Activities

- A well educated, well-trained, and fully employed work force is essential to America's economic, social, and political well-being.

- Our goal is an educated and trained work force to close the gap between worker education levels and skills and the emerging work force needs of the 1990s.

- Increased investment in education and training at all levels, including research, is the principal means whereby America in the long run can increase productivity, keep pace with technological change, improve workers' quality of life, enhance civic competency, and enable America to be strong and internationally competitive.

- Workers should maximize their educational potential through formal and informal education and training programs, and barriers to increased education opportunities for workers and their families should be removed.
- Minority recruitment, access, enrollment, and retention should be a critical element of any strategy to increase worker participation in higher education.
- Greater priority should be given by organized labor, higher education, management, and government to worker skill upgrading and retraining, with collectively bargained and employer-sponsored education benefit plans providing replicable models for effective worker education and training.
- Adequate funding is a major barrier to worker participation in higher education, and Congress should establish adequate budget ceilings for education programs in the budget resolution process which enable workers and their families to meet college costs.
- Labor and higher education have a community leadership role in the eradication of problems associated with functional illiteracy in the work place.
- Local and state-level labor/higher education partnerships and joint programs can be effective in fulfilling the Council's objectives and principles.
- Labor-campus relationships can be strengthened by creating and communicating exemplary union/higher education collaboration in teaching, research, and community service.
- Worker-learners and their families need quality educational services, and the multiple suppliers of educational services should assure such quality through accreditation, licensure, and other means.
- Governmental policies should facilitate the return of workers to education and training, which may require changes in policies that discourage worker participation in education and training (e.g., child care, parental leave, funding programs, no taxation of educational benefits, and no penalties for unemployed persons returning to education).

"Labor-campus relationships can be stengthened by creating and communicating exemplary union/higher education collaboration in teaching, research, and community service."

B. Statement: Labor in Higher Education Governance

The Labor/Higher Education Council adopted the following statement on university-college governance at its annual meeting, November 29, 1990 in Boston, Massachusetts.

While the Council appreciates that a board of trustees in an academic institution should not reflect prescribed representation of groups, given the responsibility of its members to serve the best interests of society and the institution as a whole, it urges nominating and appointing authorities to consider the leaders of organized labor for election or appointment to the boards of higher education. The Council acknowledges unions as a partner in the social contracts that help to shape our society. The Council fervently believes that the leaders of organized labor bring considerable resources, talent, and knowledge deeply rooted in the community that can be immensely helpful to boards that seek to be well balanced in their composition and expertise. These resources and attributes include representation of thousands of workers and their families interested in continuing their education, a strong sense of civic responsibility and knowledge and skills in all areas of concern to boards, including labor-management relations and negotiating skills, experience in building and construction, expertise in sound personnel policies and practices, strong constituent relations, knowledge of organizational and financial management, access to private sources of support, marketing and public relations skills, and many of the same skills reflected in the business and corporate sector of trustees.

The Council believes that governors and legislatures often miss opportunities to use talent and expertise in organized labor in their appointments to boards in the public sector of higher education. In the independent sector, nominating committees of self-perpetuating boards often do likewise.

The Council recognizes that more than one-third of all trustees and regents nationally are from the business and corporate sector of our society, even though institutional policies or state law appropriately avoid requiring such representation by quota or other prescribed "representation." Rather, so many dedicated corporate executives are trustees by virtue of the skills, talents, and access to private sources of grants and gifts that can be immensely helpful to a college or university board and its management.

At the same time, labor leaders share many of these same attributes, along with a deep concern and support for higher education, recognition of human dignity for workers, exemplary records of labor-management relations, encouragement of continuing education for their members, and joint labor-campus collaborative projects which can be helpful to boards and their institutions.

The Council urges, therefore, that greater consideration be given to the active recruitment of leaders in organized labor for trusteeships at the local, state, regional, and national levels.

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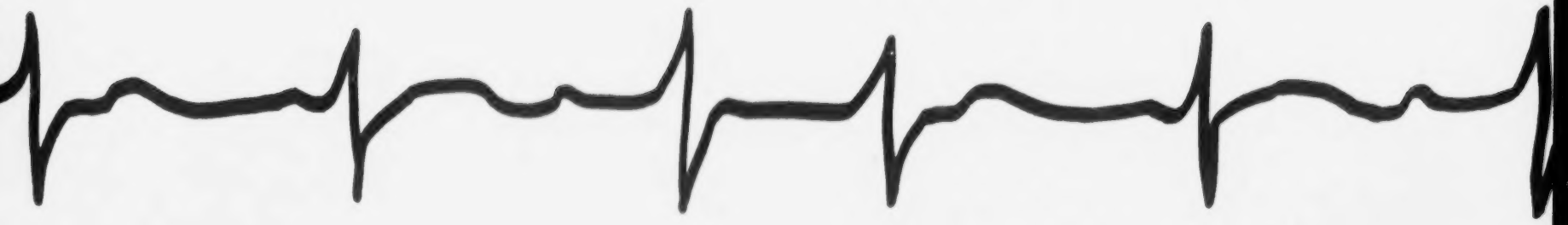

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